APPENDIX G

Heroin & Opioid Emergency Task Force
Lower Shore Regional Summit
Wednesday, June 10, 2015, 10:00am – 5:00pm
St. Francis De Sales - Philip & Barbara Long Parish Center, Salisbury, Maryland

Summit Agenda

10:00am – 10:05am	Welcoming Remarks by Father Chris LaBarge
10:05am – 10:10am	Introduction by Lt. Governor Boyd K. Rutherford
10:10am – 11:40am	County Executive and Commission/Council Presidents *County Executive Bob Culver, Commission President Jim Bunting, Jr., Commission President Larry Porter, Commission President Randy Laird, Council President Corey Pack*
11:40am – 11:55am	15-minute Break
11:55am – 1:00pm	Law Enforcement *Sheriff Joe Gamble, Sheriff Mike Lewis, Sgt. Nate Passwaters, State's Attorney, Jonathan Newell, State's Attorney William Jones, State's Attorney Daniel Powell*
1:00pm – 1:45pm	Lunch Break
1:45pm – 3:45pm	Clergy & Addiction Treatment Professionals
3:45pm – 4:00pm	15-minute Break
4:00pm – 5:00pm	Public Comment
5:00pm	Adjournment

Minutes

Heroin and Opioid Emergency Task Force
Lower Shore Regional Summit

June 10, 2015

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Wednesday, June 10, 2015, 10am -5pm
St. Frances De Sales – Phillip and Barbara Long Parish Center, Salisbury, Maryland

Task Force Members in Attendance
Lieutenant Governor Boyd Rutherford
Sheriff Timothy Cameron
Linda Williams
Senator Katherine Klausmeier
Delegate Brett Wilson
Dr. Michael Finegan
Nancy Dudley
Elizabeth Embry
Tracy Myers- Preston
Dr. Bankole Johnson

Welcoming Remarks by Father Chris LaBarge
Remarks
The church is very involved in trying to address the issues surrounding the heroin crisis. He welcomed the Task Force to try and gain new insights on how to better address the problems the state is facing.

Introduction by Lt. Governor Boyd K. Rutherford
Fifth Regional Summit of the Heroin Emergency Task Force, initiated from an executive order by Governor Hogan. The Governor and all of us here today recognize that heroin addiction is a disease, and we cannot simply arrest our way out of this problem but must address it through multiple approaches. Last year alone, there were 570 overdose deaths, more than automobile fatalities. The problem needs to be addressed using the four steps of prevention, treatment, law enforcement, and overdose prevention. Our goals need to focus on increasing the public awareness of the issue, improving access to care, and addressing drug trafficking. The main problem is addiction, not crime. The job of the Task Force today is to listen to those here to better understand how the crisis is affecting the community. By listening to others the Task Force will better understand how to develop a holistic approach to the problem.

County Executive and Commission Presidents and Health Officers
Corey Pack, President, Talbot County Council

- Talbot County is positioned in the center of the shore. There is a lot of drug trafficking in the community with a big increase in the heroin and prescription drug use.
    - Talbot County is in top three counties in abusing prescription medication

- Methadone clinic
    - There is one Methadone clinic in Talbot County similar to Turning Point clinic in Baltimore
    - Holistic approach
        - Not stop and go but treats the patient extensively

Suggestions

1. Educating parents
2. Monitoring young people who are experiencing signs of drug addiction
3. Holistic approach
    a. Physical
    b. Mental
    c. Spiritual
4. Training law enforcement to use Narcan
5. Having areas available where drugs can be disposed
6. System with additional steps where the victim can get treatment
7. Systematic handoff of a victim on Narcan between the law enforcement who administered the drug and the treatment center, jail, rehab facility etc.

Bob Culver, Wicomico County Executive

- Last year, 20 people in Wicomico County died from an overdose
    - Females under 25 are the largest abusers in the county
    - Rise in the number of prescription overdoses
- The heroin and opioid epidemic affects all socio-economic sectors of the community from the wealthiest to the poorest families
- Businesses see the drug problem as a potential roadblock when considering if they should move to the county.
- Culver believes the best thing he can do at the moment is to support his health officers

Suggestions

1. Better educate the public about the dangers of prescription drugs inside the home, i.e. the medicine cabinet
2. Tighter regulations on prescription drugs; the pharmacies are over prescribing
    a. There are better ways to manage pain
3. Infrastructure needs to be fixed to reduce drug problem

Lori Brewster, Health Officer for Wicomico County

- The drug problem has taken its toll on the community. It is her belief that everyone in the county has been affected by drug use directly or indirectly.
    - Crime
    - Family members suffering
    - Homelessness
    - Health issues
- 2007: there were only 9 overdose deaths in Wicomico County
- 2014: there were 20 overdose deaths in Wicomico County

- It has risen above the homicide rate
- These deaths are preventable

- Methadone clinic
  - Serves over 50 individuals from around the shore on a daily basis in Ocean City
- Physician in Wicomico County
  - Was prescribing opioids to over 435 patients before he was shut down for malpractice
- Prescription Drug Task Force started in 2012
  - Pilot jurisdictions for an overdose review team
- Prescription Drug Take Back Program
  - In 2012 Wicomico County designated four prescription medication disposal sites where people can safely and anonymously dispose of expired and unused prescription medications.
  - Located in every law enforcement agency in the county
  - Successful in acquiring 2,000 pounds of drugs

Suggestions

1. Invest more in peer review and recovery centers
2. Expand peer resource teams to work with people during their deepest need
3. Work with hospitals in the intensive care unit who deal with babies who are born addicted
4. Statewide campaign that will address the issue

Commissioner Chip Bertino, Worcester County Commissioners

- Worcester County is a vacation destination for thousands of visitors who bring various habits good and bad.
  - Health and law enforcement must deal with visitors too
- There is no one size fits all solution because the victims are all unique
- No fast working way to stop opioid addiction
- Many young adults are at risk because they have easy access to the family medicine cabinet
  - Starting with prescription drugs can open the door for addiction
  - Parents are left clueless
- Worcester County Task Force founded to address drug issues
  - Developed an outreach campaign to educate the community
  - Targeted schools
  - Use of social media
  - Talk at the county fair about dangers of drugs and why to avoid them

Suggestions

1. We cannot arrest our way out of the problem
2. Develop a patient approach, it takes time
3. Counseling for drug addicts

Andrea Mathias, Deputy Health Officer for Worcester County

- 78% of all the overdose deaths in the county are from opioids
- Both the opioid and heroin related deaths continue to rise in Lower Shore counties
    - Each county is required to review opioid related deaths.
- When looking at population, the death rate from opioid and heroin overdoses in Worcester County is the same as Baltimore County
- Increase in Hepatitis C and HIV outbreaks from needles
- Hired peer support staff for the heath department for addictions
- Bimodal distribution of deaths
    - Deaths seen in young people and older adults
        - Ocean City is the largest resort town in Maryland. It has the greatest population distribution of members over 65 and under 25 putting the city at risk for a large number of overdose deaths.
- HIV testing
    - Currently 117 people trained in Worcester County ranging from the sheriff to the local hospital officials and members of the community
- Naltrexone
    - $14 a dose, monthly session open to the public at the library
    - Worcester County provides naltrexone training for opioid abusers but people aren't taking advantage of it
    - Follow ups after a Naltrexone dose to ensure warm handoff to treatment center
    - Concerns
        - Naltrexone wears off faster than heroin, addicts will go back to heroin
        - Do people high off heroin or opioids have the ability to make their own health decisions?

Suggestions

1. Properly train law enforcement and first responders
2. Preventative education statewide
    a. Local messages are beneficial but a waste of money
    b. Overall message should be the same
3. Increase treatment options for drug addicts
    a. Too few people who need treatment are actually getting it
4. Request the state examine insurance coverage for counties looking to use vivitrol
    a. Make vivitrol more readily available for those who need it
5. State awareness for HIV screening and testing

Larry Porter, Caroline County Commissioners

- Caroline County is the only county in Maryland without a hospital
    - One of the most medically underserved counties
    - Poorest county
- Difficult to track drug addicts who moved to Delaware
    - Coordinating with the state of Delaware to move resources across state lines
- Treatment is too vital to hope that the private sector will fill the gap

- We cannot ask someone to wait 3 months for treatment
- There are too many roadblocks of resources for treatment due to regulations

Suggestions

1. Increase state funding to the health department
   a. Only provider of drug prevention in the county
2. Expand Access to residential treatment
3. Expand access to medication that will manage addiction
4. Urges state not to have a narrow focus when addressing the epidemic
5. Look into strategies on treatment prevention and law enforcement
6. Employing hospital coordinators to follow up with an addict after they leave the hospital
   a. This is when they are at highest risk for a relapse

Samantha Parker, Drug coordinator Caroline County

- The courts are not equipped to handle the number of drug related cases they are receiving
  - Drug addicts are flooding the system
  - Lack of resources forces courts to put drug addicts in detention centers until addiction prevention becomes available
- Wait list of 75 people for long term beds who are currently residing in detention centers

Suggestion

1. While the courts have strong family law there needs to be more investment in the recovery process not incarceration of drug addicts

Ruth Colbourne, Warden Caroline County Detention Center

- Children of drug users are twice as likely to use drugs
- Drug buyers and sellers do not stop trying even if they are locked up
  - Police recorded phone calls
- Addicts plan on getting high the day they are released
- Education can only do so much
- Caroline County has only one room in the jail for programming
  - Cutting of revenue reduces funding for programs that are not considered essential
- We have people from different counties in the jail
  - Need to coordinate with other jails and counties
- The next epidemic will be methamphetamines

Suggestions

1. Money needs to be put towards stopping the problem and without it the problem will be difficult to solve
2. We need programs that involve prevention and education
3. Educate inmates in jail about Narcan and HIV testing

John Winslow, Addictions Program Director for Dorchester County

- Coordinated with National Council on Drug and Alcohol
  - Number of drug users in Dorchester County is skyrocketing
    - Beyond heroin and opioid substances.
- Solving the problem through one institution or task force is impossible
  - We need problem solving advice from everyone (all areas).

Suggestions

1. A successful approach is to learn from those who have been through the recovery process
   a. See what worked for them
2. Primary prevention
   a. Improve how culture promotes alcohol on TV and at sporting events
   b. We need legislation to hold pharmaceutical companies accountable for the promotion of opioids
   c. Educate the public, youth, family members
3. Secondary strategies
   a. Assist those who are at risk of becoming addicts to drugs by building a recovery environment in the community
   b. Family member presence during the recovery process to help addicts regain a normal lifestyle
4. Tertiary risk
   a. Help those who are abusing
      i. Recovery high schools
      ii. Collegiate recovery centers
      iii. Peer presence in detention centers
      iv. Provide vivitrol to those looking to reenter the community
      v. Fund full range of treatment measures

Randy Laird, President, Somerset County Commissioners

- United States accounts for 5% of the world's population yet it consumes 80% of the worlds opioids
- Most of the people addicted to opioids will eventually turn to heroin
- Over the last five years Somerset County has 13 deaths caused by heroin
- There have been 825 non medical cases involving opioids resulting in 32 hospital visits
- Many addicts lost all of their money, family members, parents, grandparents and do not know how to help
- In 2005 Somerset County began prescribing Narcan
  - Doctor an prescribe up to 120 patients

Suggestions

1. Media campaign educating people on the proper disposal of drugs
2. Wellness center to house drug addicts
3. The abuse of opioids is costing government money

a. They need to reduce the amount of opioids on the market

Craig Stofko, Health Officer for Somerset County

- Most health departments follow the same programs because of funding that comes from the state
  - Occasionally health departments step outside the box
- 2005 drug rehab program focused on retention rate and successful treatment
  - It was two to three times more successful than similar programs
  - Outperformed other programs because it took Medicaid
- Science has proven addiction is a disease
  - Drugs are just as important as food, water, and the air we breathe to addicts
- Worked hard over the past 30 years but the progress has been slow
- What can we do to unclutter the ER's and morgues?
  - The answer can be written on the prescription pad
    - Medicine treats symptoms

Law Enforcement

Talbot County Sheriff, Joe Gamble

- Call received two years ago about a murder
  - Found out it was a young man he coached
  - It wasn't a heroin overdose but it was a synthetic drug
  - Purpose of story
    - There were about 60-70 teenagers in his community
    - 40% of them were doing heroin, pills, and drugs exc.
    - Shocked that it was so prevalent
- The parents in Talbot County do not know the path to heroin
- There are two public and one private school in the county
  - Found there was at least one student who was a heroin addict
  - Earlier they start experimenting, the earlier they get into prescription drugs
  - No child has not gone through heroin without drinking
  - Path
    - Drinking → Marijuana → Pills → Heroin
- Today it is easier to get drugs than it was in the past

Suggestions

1. Parent prevention programs
   a. Current situation
      i. Parents are being parents but they just are not aware of their child's addiction
      ii. Children will listen to their parents
2. Better education and early intervention programs for parents, mentors and children

Wicomico County Sheriff, Mike Lewis

- The problem started seven years ago when many well qualified physicians began overprescribing medication
- The police knew that when physicians were arrested for overprescribing the number of heroin addicts would increase
    - This statement has held true
- We cannot arrest our way out of this problem
- In Wicomico County many of the deputies have been trained and armed with Narcan
- Personal accounts
    - The Salisbury Sheriff wanted to use a public restroom but the door was locked
        - Found a dead man inside with a needle in his arm
    - Officers stopped a drug trafficker from New York with enough heroin in his possession to supply 42,000 Maryland residents
        - The man had multiple weapons in his possession when officers searched his home
- Decriminalization and legalization of marijuana is a main cause for why young kids have started using marijuana.
    - We have a duty first and foremost as parents to fight this issue

Lt. Bill Crotty, Delaware State Police

- The state of Delaware has seen tighter regulations with prescription pills and medication
    - Increased regulation of pills has led people to use heroin as an alternative, causing its use to be considered an epidemic.
- Delaware Information and Analysis Center
    - Allows officials to track best practices of other states, organizations, and groups regionally and nationally
- The Delaware state police work with the police in Philadelphia to track drugs coming into the area through alerts
- Residents have a personal obligation to notify authorities if they see drugs in the area
    - Drug addicts can also notify the police if they have valuable information regarding a drug alert

Matt Maciarello Wicomico County State Attorney

- Building collaboration between the law enforcement and partner agencies
- Wicomico County has an opioid processor.
- The federal government listed Wicomico County as a high trafficking drug area
    - Further listing it as a fertile ground for drugs
- Most students in the county qualified for reduced lunch
    - Wicomico County desperately needs state resources
- PDMP Prescription Drug Monitoring Program
    - Allows us to see what other doctors have prescribed
- General Concerns

- Privacy issues with Narcan
- Health department cannot follow up will all the patients it sees
- Year of the criminal in the Maryland General Assembly
  - Resulted in watered down drug laws
  - We cannot fall into the mantra that believes the law enforcement won't help stop the problem
- Retailers in the area feel threatened i.e. Wal-Mart being robbed
- Developers build a beautiful building but the copper wiring inside was stolen by a drug addict

- HB 222 – targets drug dealers and manufactures in heroin related deaths
- Some dealers will not cross the Delaware line because of Maryland's strict laws

Suggestions

1. Collaboration between law enforcement and the health department
2. Investment in health and mental services
   a. HIV is a concern
3. Have sister states; Delaware and Virginia work together with Maryland
4. Develop a holistic plan for the state
5. Arresting heroin and opioid users is not the full solution but we do need to arrest drug traffickers

Caroline County State Attorney, John Newell

- The key to combat the heroin crisis is awareness
- It is hard to explain to children about dangers of drugs when marijuana is getting legalized and decriminalized around the country
- HB 255 -- search and seizure is a major tool for law enforcement
- One year ago a move was made to pull state police out of local Caroline County Task Force
  - Caroline County does not have a hospital so it needs a police presence on the Task Force
- Caroline County needs support of the state police on the local level
- Addicts are leaving the county because the law enforcement is cracking down on them
- Increase in the number of methamphetamine labs in Caroline County
  - Police found one lab in 2014
  - Police found five labs since the start of 2015
- Some stores still sell illegal items because they haven't updated their documents
- Child fatalities are a direct result of heroin and opioid abuse
  - Children are being born addicted to heroin
- Real life example
  - Heroin addicted mother gives birth and tells the hospital staff to call her when her baby stops screaming
    - Babies aren't given much of a chance
- Praised the state government for not funding the juvenile system, who Newell says wastes the states tax dollars.

Dorchester County State Attorney William Jones

- Heroin showed up a few years ago in Dorchester County and Jones did not realize how much of a problem it would be until the cases started piling up
- Dorchester County has a drug prosecutor dedicated to all heroin related cases
- The non-violent drug offender is serving decades of time for dealing and manufacturing heroin
    - They are putting young people at risk
    - We need to get rid of the notion that drug traffickers need to be treated differently
- Drug treatment court
- Police have done a great job with heroin investigations
- Dorchester Drug and Abuse Council
    - Consists of people in the community who come up with ways to combat substance abuse
- Common themes
    - Heroin users start on pills because of an accident, injury, or access to other people's prescriptions
    - Today our society encourages the use of pharmaceuticals drugs to solve our problems
        - We need to realize that we don't need to be so medicated
- OARRS - Ohio Automated Rx Reporting System established in 2006
    - Controlled by the Ohio State Board of Pharmacy
        - "The state board of pharmacy may establish and maintain a drug database. The board shall use the drug database to monitor the misuse and diversion of controlled substances"
        - Ohio HB 341 requires prescribers of opioids to register to use OARRS
            - When a doctor prescribes a certain medication they must record it within the system
            - Furthermore a doctor in a jurisdiction bordering another state must register with that neighboring state too.
            - Doctors who violate the system will be issued a civil penalty of $500
            - Also doctors can be disciplined by the board of physicians

Suggestions

1. Continued state funding is essential to fight heroin problem
2. Eliminating access to pills will help to reduce the number of heroin users

Somerset County State Attorney Daniel Powell

- Most economically challenged county within the state
- Law enforcement takes their oath seriously

- The increased perception is that those in law enforcement are out to get you but Powell tells the public that's not the case

- Safe Streets Program
  - "The Maryland Safe Streets Initiative (Safe Streets) is an offender model established to institute collaboration and information sharing across all levels of government to dramatically reduce crime." - the Governor's Office of Crime Control & Prevention (GOCCP)
  - Program has been effective in Crisfield, Cambridge and Salisbury
  - Partners with juvenile professionals, members of the community, local state and federal law enforcement
  - Engaging youth by talking to them about drug problems
- Personal experience dealing with drug dealers as state attorney
- We don't put drug dealers away for 5-10 years but they go to jail for a long period of time
- The notion that drug dealers are stupid people is false. They are smart and know the economics of making money
- Powell only has four people to help him patrol a county of 25,000
  - Lacks resources to bring drug dealers to justice
- Funding was also cut for the local juvenile drug court
- There has been talk about establishing regional drugs courts
  - Problems
    - It is difficult to provide transportation to those on trial
    - Lack of funding

Suggestions

1. Somerset County lost funding for the Safe Streets Program and needs the state to replenish the funds. Without the program the county has seen an increase in drug use and a lack of education about drugs.
2. Watering down of public offender laws and legalization of drugs is not the answer
3. Many drug users from Somerset County were able to attend a successful local drug treatment program (2005-2010) at the Wicomico County detention center
   a. Program lost its funding, need to find a way to revive the program

Clergy and Addiction Treatment Professionals

Pamela Hay (Center 4 Clean Start)

- Licensed clinical counselor
- Operates an outreach and treatment program for pregnant women with a substance abuse problem
- Center 4 Clean Start serves four counties and partners with a half-way house
- Only has a staff of six members but the case load includes 30-40 individuals on monthly basis
- SB 512 Children in need of assistance – drug addicted babies – parental rights act
  - Identifies and treats women with heroin and cocaine addiction
  - Marijuana added to the list of drugs
- 2013: 78 new additions to the Center 4 Clean Start 34% had an opioid addiction

- 2014: 81 new additions to the Center 4 Clean Start 46% had an opioid addiction, 63 women were pregnant
- Pregnant women are ashamed by anyone around them.
    - The women don't want anyone else to know of their problem
    - Many of the mothers feel better about themselves surrounded other women abusers
    - The women feel comfortable around their friends
- Very few doctors will prescribe pain pills for pregnant women
- The Wicomico Methadone Clinic is very helpful but women with small children have trouble with the clinic hours because they cannot come in the morning
- Transportation issues
    - Most women do not have cars to get to the clinics

Suggestions

1. Work more closely with local clinics
2. Create transportation that will be available for women
3. Have the clinics take into account time sensitive schedule's of mothers
4. Easier assess for purchase of care

Leslie Brown (Hudson Health Services)

- President and CEO private non profit organization working for people who abuse drugs
- Operates three half-way houses that employs 70 people who treat 1,500 patients
    - Offers in-patient detox
- A recovery house in Salisbury is located right next to a drug dealer.
    - All the addicts have to do is go next door if they are struggling
- In January 2014 Medicaid expanded to cover every person under the Affordable Care Act
- In January 2015 all residential treatment facilities informed Medicaid patients that they would not be reimbursed
    - Forced them to go to a hospital where prices were four times as expensive
    - Hospitals in the area are not prepared for the onslaught of patients

Suggestions

1. Consider putting funding into detoxification centers for state facilities
    a. Addicts must be treated matching severity of the disease
    b. Offer addiction and recovery specialists for hospitals
    c. Access to psychiatrists
    d. Education in schools

Heather Brown (Eastern Shore Psychological Services)

- Admissions supervisor for Eastern Shore Psychological Services for the past two months
- People who come in for treatment are mostly using opioids
- Uses four dimensions of the recovery model when treating patients
    - Home, health, community and purpose

- Helps to provide educational services
- Concern arises when the patients leave the center and don't have the four dimensions anymore
- When patients are in treatment we provide them with transportation to and from the center
    - Transportation is a huge barrier
- Two individuals who are patients at Eastern Shore Psychological Services live at a recovery house located in the highest crime area in Salisbury next to drug dealer
    - It's the only place they can afford
    - We want addicts to get the best treatment but in reality most aren't able too
- Adolescent population
    - We need to provide patients with a safe place to stay
    - Example
        - Teenage boy is the head of the house and is forced to provide for his family because his dad is in jail
        - He resorts to drug dealing as a source of revenue
        - We are pushing him to stay but when he leaves we cannot continue his treatment
- Early education on drug use
    - Working with Department of Social Services to connect with children
- Psychological testing of family
    - Currently working with the Department of Social Services to look at the family
        - I.e. how the parents addicted interact with the child
    - When a child is born addicted it needs to develop healthy habits
    - It is challenging for children ages 4-5 who are born addicted to develop an attachment with their parents
- Those who are addicted but also have a mental problem can receive more services
- The ultimate goal is to keep the family together but some children have to go to foster care where they will be put up for adoption
- Women who have been in human trafficking and used drugs come in for treatment
    - Transportation is provided for them

Rev. Bryan Lloyd

- He believes that there is an opportunity to make a difference and significant impact by helping those affected to recover
- He struggled with heroin addiction for ten years
    - Consumed every aspect of his life
    - Hurt his family
    - Overdosed multiple times
    - Felt like he could never overcome the addiction
    - Contemplated suicide
- How faith based community can make a difference
    - He wanted to stop but he had no idea where he could get help

- He eventually found a local church that led him to a treatment facility in Salisbury that saved his life.
- He believes that finding God is the only reason he is still alive today

- Questions people ask the Reverend
  - Pastor what do I do if a loved one is addicted to heroin?
  - How can I get my family member help?
- People don't call their doctor, local health department or treatment facility caused by the shame and guilt of their addiction
  - They instead call their local pastor or faith based organization
  - We try to meet them where they are
- A two year national study on addiction abuse cites that spirituality is crucial to over come addiction
  - Adults are 4x more likely to use drugs if they don't think religion is important
  - Teens are 7x more likely to use drugs if they don't think religion is important
- The church has created a partnership between state programs local physicians and treatment facilities
  - Personally helped to connect 12 addicts with the health department and treatment facilities
  - Currently 7 of the 12 addicts are off drugs
- What would happen if the entire faith based community created partnerships with health department and treatment facilities?
  - If every faith based organization within Maryland created partnerships with local health and treatment facilities it could change tens of thousands of lives
- By forming lasting partnerships with health providers we can prove to the Task Force that they should look to the faith based community to address the drug problem.

Bruce Strazza (12- Step Program)

- It has been about 19 years since his brother Mark overdosed on heroin.
  - Even though drugs such as methadone and suboxone would have probably kept his brother alive, Mr. Strazza believes they are a crutch for addicts to keep abusing
- Heroin addicts detox go through facilities and come out with no job, sometimes even homeless
- Drug addicts have no way to pay for half-way houses unless their family does
  - Addicts make it two weeks with paying and then they're back on the street
- He is sponsoring a man who committed a non-violent crime. He admitted it was the man's fault but he asked the task force
  - How do we help this man who cannot get a job?
  - He admitted, "I don't know the solution but I know people like you can make a difference."
- He has gone around to local community centers and churches advertising the opioid response kit

- It costs $50 to purchase and includes two doses that can save a life
- Talbot County has trained 21 people

- Drug Prevention
  - Has a friend who teaches health education in Anne Arundel County that had addicts come in and talk to his students
- Methadone clinics are cash based not insurance based
  - Personal experience
    - He would drive 100 miles to buy methadone with cash and then sell it to other addicts
    - Supplies market with more drugs

Suggestions

1. We need to look into having the state invest in the opioid response kit
2. Mr. Strazza said he has no knowledge of budgets but he urged the state to make funds available to help drug addicts
3. Take a real life addict into the classroom to talk to middle school and high school kids
4. Have Maryland release public service announcements on where to get help
   a. Billboards, TV, Internet

Josh Webster (Warwick Manor)

- Addiction Counselor at Warwick Manor Behavioral Health Center since 1974
  - Employs 120 Eastern Shore residents
  - Facility has 64 beds for patients
  - Had over 1,800 Maryland residents go through detox treatment in 2014
- Medicaid
  - As of January 2015 Warwick Manor has to turn away 5-8 people a day who have no place to go because the price of detox has been raised
  - They are able to provide levels of care for Delaware Medicaid and insurance but not for Maryland Medicaid.
    - Medicaid funding went down 23% to $130 in 2014 and 43% to $110 in 2015
    - 2014: we accepted 95% of patients on Medicaid
    - 2015: we are only accepting 65% to 75% of patients on Medicaid
    - Might have to close Warwick Manor if Medicaid does not become more affordable to
- IMD waiver exclusion does not allow Warwick Manor to be reimbursed by Medicaid
  - Barrier to provide non-hospital inpatient medical care
- Transportation
  - Warwick Manor treats people from all over the state of Maryland Baltimore, Fredrick, the Shore, Southern Maryland
  - Patients are driven to the facility
- The longer the patients are in treatment the better the outcome
- Patient Demographics
  - Middle class drug addicts

        - In the minority
        - Have social economic support systems
    - Lower Class
        - 95% of patients last year
        - On Maryland Medicaid
        - 50-60% are homeless
- 90% of the population has had a secondary psychiatric diagnosis of mental health problems and depression

Suggestions

1. Make changes in legislation that will make it affordable to service those with Maryland Medicaid

Diane Hitchens (Peninsula Regional Medical Center, Nursery)

- Has a public health perspective
- Drug impact on pregnant women
    - NAS Neonatal abstinence syndrome
        - Babies are born in withdrawal
        - Experience symptoms within 2-10 days of life
        - Fussy, hard to eat, constant crying
    - Drug testing for babies
        - Carried out if the mother has high risk behavior or her test is positive
        - Scores decide how severe the withdrawal is
- Neonatal abstinence syndrome (NAS) cases
    - 2015 average cost per infant $19,121
    - Total cost hospital charges for all infants $1.2 million
    - Average hospital stay per infant 29 days
- Hospital demographics
    - 2012
        - 2077 deliveries
        - 148 moms exposed to drugs
        - 38 infants treated for NAS
    - 2013
        - 1970 deliveries
        - 210 moms exposed to drugs
        - 29 infants treated for NAS
- Over two year period 2012-2013, 67% of NAS infants require treatment and 17% infants require second treatment
- 2014 statistics of pregnant mothers at time of birth: 46% were using drugs marijuana, 28% were using opioids, 11% methadone, 6% cocaine
- Cocaine may induce labor and it should be looked at
- A lot of mothers sign themselves out after they give birth and go back to using drugs
    - The community of substance abusing mothers think they know more than the care providers

- Facility has special care nursery of 12 beds
    - On average some babies are there from 25-45 days
    - Parents are upset that facility is keeping their baby
    - Babies could have a seizure and not survive if they don't stay in the nursery
    - Addicted mothers have difficultly to stay awake with holding the babies
    - Security issues include domestic violence of mothers and fathers fighting within hospital grounds

Suggestions

1. A private room in the facility for the mother to go through withdraw together with her baby
2. Standard drug test across the state of Maryland
3. Mandatory education when drug users test positive
4. A small team of psychiatrists, counselors, and members of the faith based community to work with the mothers
5. Look at the teen challenge in Delaware- faith based substance abuse disorder program where mothers go for one year with kids up to 5 years old
    a. 80% success rate

Jim Freeman (Second Wind, Inc.)

- Certified drug and alcohol counselor
- Works at Second Wind: 42 year old halfway house for homeless men and addicts
- Second Wind receives a small grant from the state
- Treats men seeking an abstinent based recovery program
- Believes that the men need a safe long term program that will support them daily
    - Curfew structure
    - Positive role models
    - Held accountable for actions
    - Responsible for their workplace and community
    - Home cooked dinner
    - Family sessions
    - Proper housing environment
    - Job searching
    - Mental health management
- Recovery houses don't offer the above support structure besides housing
- Personally receives 3 to 4 calls a day about men in recovery houses seeking the support of a halfway house
- Six months in halfway house will give addicts the physical, mental, social and spiritually tools they need to recover
- The treatment of heroin and opioid addiction must be individualized based on that persons specific signs and symptoms
- Even though methadone is an amazing medicine but alone will not resolve the heroin crisis

Suggestions

1. Halfway houses need to be funded by the state
    a. The cost cannot be passed on to residents
2. Minimum detox of less than a week is not enough for addicts to lose their long term heroin addiction
    a. "Cruel and insane to think it will fix an addiction"
3. Putting people on methadone without proper means of change is a recipe to go back to heroin

Father Crystal Barge

- Bottom line
    - The faith based community can be supportive and help with case management
    - More specific religious recovery groups and retreat weekends
- "We are talking about a disease not a moral failure"
    - "The more we treat it like a moral failure the more people feel alienated"
- "We would never tell someone who is fighting cancer your medical treatment is only 3 days and you have one weekend in recovery"

Suggestion

1. The medical professionals should decide how long the treatment is and not the insurance providers

Public Comment

Theresa H.

- Mother of a heroin addict
- Social worker
    - Met regularly with addicts and juvenile offenders who need resources
    - Discovered addiction crosses all socioeconomic statuses
    - Befriended a boy named Jacob who was musically gifted at the age of 18 and hoped to attend college
        - He became addicted to heroin and for the next eight years went through severe struggles
        - She saw Jacob needed help but there was not much she could do
        - Jacob was able to spend ten days in a clinic but he had a relapse
        - Time in recovery wasn't long enough to make a permanent change
        - Jacob also spent time in jail but he did not receive any help for his addiction when he was released
    - Relapse is certain unless community provides help and education
    - Jacob hopes to have a family and a home but that goal is far out of reach

Suggestion

1. The state needs to make resources readily available to address the epidemic
2. In favor of community involvement as an alternative to incarceration

Penny Glasgow

- Son addicted to opioids

- Honor student and an athlete
- On May 17, 2003 her son got into a car accident after junior prom and had to have a surgical procedure
  - Doctor prescribed him pain killers after the surgery
  - Became addicted shortly after
  - Lost numerous jobs
  - Had many relapses after trying to get clean
- General community consensus is that you make the choice
- Mrs. Glasgow's view: He was born with his addiction because it runs in the family.
  - He did not make a choice but he was fighting a disease and it should be treated as such.
  - Tried to get treatment from her son

Suggestions

1. Incarceration is not the answer
2. We need to get addicts the resources they deserve so they can receive treatment

Laura Mitchell

- Son addicted to heroin
- Disgusted that the state is still just talking instead of acting on the problem
- Upset parents cannot get access to information about their own children.
- Disappointed that Vivitrol is not readily available to every addict
  - 7 to 10 days in a treatment center not enough
- Methadone is a crutch for addicts to return to opioids or heroin
- This epidemic is everyone's problem!

Suggestions

1. Allow all inmates in jail access to Vivitrol not just the ones who have proper insurance
2. Support systems are needed to make an impact
3. How can the state pay for 18 months of incarceration for a theft but not 6 months for a drug addict in a treatment center.

Valerie Albee

- Daughter was addicted to opioids and heroin
  - Died on Sept 7, 2012 from an overdose
  - She was a bright student
  - In the 8th grade she was bullied
  - Suffered from depression and anxiety
  - Doctor at John's Hopkins misdiagnosed her with bipolar disorder
  - In high school years had addiction to alcohol and drugs
    - 6 months into senior year the addiction was so severe she couldn't get out of bed

    - She ended up taking pills and spent time in and out of rehab
    - Sent her to a treatment center in Georgia
- Personal struggles
    - "I don't have a daughter anymore and I won't have grandchildren"
    - "I wanted to jump off the bay bridge"
    - Mrs. Albee mentioned she started a support group in St. Michaels where parents of addicted children can come and talk
        - They shouldn't feel alone
- The face of addiction is everyone not what people think

Pamala Eichelberger

- Lost her son to an overdose
    - His addiction started 8 years ago.
    - She had him in counseling while he was at school
    - He developed more behavioral issues, as he got older.
        - She found large amounts of cash and marijuana in his bedroom.
- Personal story
    - One day she was pulling out of the driveway and saw her son sitting on curb with police
    - The police found him in a drug dealers house when they raided it
- At the time her family moved to Pasadena she thought it was a good area
    - Drugs were all around the school and community
    - Anyone can have an addiction not just your stereotypical addicts
    - Son stayed in court ordered rehab for 28 days
    - He has the inability to make decisions on his own
    - "If we can save another family from the pain I went through its worth it"

Ashley Pruski

- Recovering addict
    - Did not have the education available to hear about the support systems and groups that could help her
    - She said she still does not know all that's out there in terms of where and how to get help
    - Her family had no idea what to do.
    - Had insurance issues with the rehab facility she was attending
        - Could not stay because of a court date.
    - Spent time in jail where she had time to figure her life out
    - She believes that attending rehab for 28 days would not have been enough for her to fully recover

Suggestions

1. Increase education on how recovering addicts can raise a child
    i. She has a son and her husband is also a recovering addict

Breta Still

- Went to a pain management clinic run by a Salisbury doctor

- She knew she had addiction issues
- Doctor was too lenient with prescriptions he was giving out
- DEA shut his practice down
- All addicts who were previously on pain medication now have nothing
- The addict could not afford to buy pills off the street so they switched to heroin
- Addiction rate probably rose about 80% after the pain management clinic shut down
- Hudson Health Center
  - Employees treat patients like "dogs"
  - Facility is mainly an open hallway with no place to sit.
  - Many people are not getting the help they need
  - They are kicking addicts out for being addicts.
  - If addicts forget their ID or bottle they don't get their dose of medicine
  - People treat it like a choice not a disease

Suggestions

1. Make it easier on parents to get their children help by having one number that parents can call
2. Health department needs more funding to pay employees. Currently has the same number of staff as the Hudson center but services twice as many patients.
3. An investigation needs to take place to look into mistreatment at the Hudson Health Center

Jackie Ball

- Son is a 24 year old heroin addict
  - Currently an inmate in the Worcester County jail
  - Started using drugs at the age of 15
  - She spend her son's college savings to send him to a one year rehab facility in Utah
    - Confident that when he returned he would make good choices
  - As a senior in high school her son was put it back into same environment he left and started using drugs again.
  - She later thought that sending him to college would give me a purpose and get him away from his old friends
    - While at college his addiction worsened
    - Used oxycodone and heroin
    - Spent time in six rehab facilities and four half ways houses.
  - Mrs. Ball gave up her entire life savings and college savings to try to help her son
  - Her son has been in and out of jail
    - He has been offered no treatment while jail
  - Every time an addict violates drug court they have to stop taking suboxone

- Judge told her son he will send him back to prison because he made the choice to do drugs
- Mrs. Ball believes his addicted brain makes him use drugs
  - During a prison visit her son said he has no idea how to stop

Suggestions

1. Rehab facilities should be rated.
2. Insurance needs to cover stays at rehab facilities
3. Have treatment options available in jails
4. Find a way to subsidize Vivitrol; it is $1,200 for one dose

Mary

- Son addicted to heroin
  - He was successful and athletic
    - Played football, basketball, and baseball
  - He started on drugs at the age of 15; He is 35 today
  - Addiction
    - Marijuana,
    - Heroin
    - Cocaine
    - Pills
  - Drugs were easily made available in the school building
  - Mary sent him to receive treatment from a psychologist and psychiatrist
  - He overdosed during his senior year of high school and was found unconscious
  - Spent 9 weeks in a drug treatment program
  - Visited many facilities that did everything they were supposed to do to help him but he is still addicted
  - Has legal trouble because of his drug problem
  - He told his mother when you hit rock bottom during addiction you go down even further
  - Received no treatment for his addiction in jail.
  - He wants to become an advocate against using drugs when he gets out of jail

Suggestions

1. Get treatment for drug addicts who are in jail
2. Help convicted felons get employment when they get out of jail

John

- Recovered alcoholic and drug user pills
- Has a six year old son named Gus
  - He was going to kill himself but decided against it when his son was born
  - He realized he needed to make a change and be there for his son
- Any chemical you start putting in your body will affect it

- When young people use drugs it affects them negatively because their brain and bodies are still developing
- Neurons in the brain are not fully developed until a person turns 25. When someone uses heroin before then they become addicted because the brain cries out for the heroin when the user is off it.

County Executive and Commission Presidents & Health Officers (10 mins)

- ✓ Larry Porter, Caroline Co Commissioners
- ✓ Caroline County Circuit Court and Corrections person — ✓ Samantha Parker & Ruth Colbert
- ~~Rick Travers, President, Dorchester Co Council~~
- ✓ John Winslow, Addictions Program Director for Dorchester County
- ✓ Randy Laird, President, Somerset Co Commissioners
- ✓ Craig Stofko, Health Officer for Somerset County
- ✓ Corey Pack, President, Talbot Co Council
- ✓ Neil Corneilus, Director of Addictions for Talbot County
- ✓ Bob Culver, Wicomico County Executive
- ✓ Lori Brewster, Health Officer for Wicomico County
- ✓ Commissioner Chip Bertino, Worcester Co Commissioners
- ✓ Andrea Mathias, Deputy Health Officer for Worcester County

Law Enforcement (7 mins)

- ✓ Talbot County Sheriff, Joe Gamble
- ✓ Wicomico County Sheriff, Mike Lewis
- ~~Worcester County Sheriff's Office, Sgt. Nate Passwaters~~
- ✓ Lt. Bill Crotty, Delaware State Police
- ✓ Caroline County State's Attorney, Jonathan Newell
- ✓ Dorchester County State's Attorney William Jones
- ✓ Somerset County State's Attorney, Daniel Powell
- ✓ Wicomico County – Matthew Maciavello

Clergy & Addiction Treatment Professionals (6 mins)

- ✓ Leslie Brown (Hudson Health Services)
- ✓ Heather Brown (Eastern Shore Psychological Services)
- ✓ Pamela Hay (Center 4 Clean Start)
- ✓ Bruce Strazza (12-step program)
- ✓ Josh Webster (Warwick Manor)
- ✓ Rev. Bryan Lloyd
- ✓ Jim Freeman (Second Wind Inc.
- ✓ Diane Hitchens (Peninsula Regional Medical Center, Nursery)

~~[illegible]~~ Father LaBarge

Public Comment (3 mins)

- ~~Kathleen Decoudes~~
- ~~Joseph Derbyshire~~
- ~~Stephanie DuBrel~~
- ~~Chris Butler~~
- ~~Lisa Hayes~~
- ~~Lorrie Sonnier~~
- ~~Gregory Robbins~~
- ✓ Laura Mitchell
- ~~Diane Lane~~

~~Wendy Truzerls~~

~~Sherry Collier~~

~~Les Simering~~

✓ Valerie Albee

✓ ~~Pamela Eichelberger~~

~~Kimberly Bateman~~

~~Joanne Janvier~~

~~Cindy Yost~~

✓ Penny Glasgow

~~Bette Jo Shifler~~

✓ Ashley Pruski

✓ Breta Still

[redacted]

~~Detective Ralph Oakes~~

~~Kerri Fisher~~

~~Janet Lane~~

~~Jim Freeman~~

~~Rev. Jason Heil~~

~~Jena Taylor~~

✓ Ann Youngblood

~~Leslie Brown~~

~~Dr. Andrea Mathias~~

~~Jennifer Lamade~~

SIGN IN SHEET FOR PUBLIC COMMENT
Lt. Governor's Drug Task Force Meeting - Salisbury
DATE: 6/10/15

Time	Name	Town of Residence	Phone/Email
9:30	~~Nancy Shockley~~	Dorchester Co	410-228-0251 nshockley@docogonet.com
0930	~~Jo-Anna Schanno~~	Berlin MD	410 4024349
~~0930~~	~~James Henry Caroline Co Sheriff~~	~~Greensboro, MD~~	~~443-786-2924~~ 2A
	~~Dale [illegible]~~	~~(Caroline DSS)~~	~~410 [illegible]~~
	Jackie Ball	Ocean City	jackie94@comcast.net
	~~Cory Fink, DSS~~	EASTON, MD	
	~~Sgt George Paugh~~ EASTON POLICE	EASTON MD	410-200-1970 georgepaugh@town-eastonmd.com
	~~Commissioner Mary Dennard~~	Dorchester Co	410 330 0152 mdennardturner@yahoo.com
	~~Kennedy Hinman~~	Salisbury, MD	Khinman@hudson-health.org
	~~Laura Mitchell~~	Salisbury MD	laura@lauramitchell.org 410-422-2094
	~~RANDY & BARBARA WALTER~~	BERLIN	410-641-3953 shilohministries@comcast.net
1000	~~Chief Jeff Jackson~~	Greensboro	jjackson@greensboromd.com
1000	~~Andrea Mathias MD MPH~~	Snow Hill, MD	andreamathias@maryland.gov
	Theresa Hathaway	Salisbury MD	hathnestheresa@gmail.com

SIGN IN SHEET FOR PUBLIC COMMENT
Lt. Governor's Drug Task Force Meeting - Salisbury
DATE: 6/10/15

Time	Name	Town of Residence	Phone/Email
10[00]	~~Holly Ruland~~	Centreville, MD serve 5 mid-shore counties	410-770-4801 hiveland@msmhsorg
10[10]	~~David Gray~~	~~Salisbury, Maryland~~	410-219-7487
12[15]	~~Michelle Hardy~~	Hebron, MD	410-339-3497
400	~~Pete Steel~~	Salisbury	443-235-7820

Public Health
Prevent Promote Protect
Wicomico County
Health Department

Wicomico County Health Department
108 East Main Street • Salisbury, Maryland 21801

Lori Brewster, MS, APRN/BC, LCADC • Health Officer

June 10, 2015

Thank you to Lt Governor Rutherford for convening this important taskforce, and for all the taskforce members for your service. I am Lori Brewster, the Health Officer for Wicomico County. I am grateful for the opportunity to be able to speak to you about the issues that heroin and opioid abuse presents for our County. Unfortunately, you cannot speak to anyone in the area that has not been affected by the problems of drug abuse in some way. Heroin and opioid abuse affects many aspects of our community and is one of the issues behind poverty, crime, homelessness and other health issues. We are very pleased that County Executive Culver made addressing heroin a priority and assigned one of his transition team members to this issue.

Saving people's lives is the goal of our recommendations. Last year, twenty Wicomico County residents died from overdose. While the numbers are small, one life lost is one too many as these deaths are preventable. To put the issue in perspective Wicomico County had a total of 9 overdose deaths in 2007. We are up by 11 deaths in 7 years. That is more than the number of homicides in the County for the same period.

Wicomico County is currently sixth in the state for heroin as primary substance for treatment admissions. We have seen an overall increase from 9 percent heroin related treatment admissions in 2010 to 23% in 2014.

Wicomico County Health Department is one of only two methadone treatment programs on the Eastern Shore. Four years ago we had a total of 25 patients accessing methadone treatment. Today we have approximately 270. The volume continues to increase with a concentration of individuals in the City of Salisbury.

The approach to addressing the issues surrounding heroin and prescription opioids must be multi-faceted. One approach will not move the needle for overdose deaths. In Wicomico County we have taken on many initiatives to begin to address the increase in overdose deaths and the use of heroin and other opioids. In 2012 Wicomico County began a Prescription Drug Task Force in response to the increase issues surrounding prescription opioids in our community. We had a local pain management specialist close their doors due to issues related to prescribing practices. This resulted in patients

Maryland physicians have access to the Prescription Drug Monitoring Program (PDMP). There is no current requirement for them to use the PDMP. Perhaps a legal requirement for use would help curb the over prescribing of prescription opiates.

The tragic suffering of babies with neonatal abstinence syndrome is horrible to witness and very costly to the healthcare system. Changes in the legal system to facilitate routine treatment of all pregnant women with positive drug screening would help alleviate suffering and expense.

Many of the individuals incarcerated in the local jails suffer from heroin and prescription use. Expanding availability of treatment options in the jail including the prescribing of naloxone upon release would assist this population greatly. One of the most vulnerable periods for a person addicted to heroin or opiates is upon release from incarceration. We need to address this vulnerability.

Finally, we need to increase access to those individuals who had a nonfatal overdose. Information on these cases is vital to addressing interventions to preventing these near misses and the fatal overdoses. Peer counselors being co-located in Emergency Departments could assist in addressing this issue.

Sincerely,

Lori Brewster, MS, APRN/BC, LCADC
Health Officer

Butte Silver

ADDICTION

AN EPIDEMIC

WHY HERE

- 1990-early 2000's Culture of Pain Management

  1-10 scale, how is your pain…

  very concerned about pain

- Early 2000's to Now Culture of Pain Mgt.
  - No scale questions, not as concerned with pain
  - Culture of "its not that bad"

Crucifixion of Dr. Fox

- DEA and State closed him down, for whatever reason…
- Patients followed guidelines that was put out to media:
  - See primary care provider, they will treat you until they get you into a new pain management.
  - This did not work. PCP's were scared to death to prescribe anything. My doctor did not give me anything.

Crucifixion of Dr.Fox Cont.

- All pain managements, 2 in Salisbury were backed up for months. I was referred to a place in Seaford Delaware that always had a waiting list. If you said the name Dr. Fox, you were automatically an addict.
- I went to WCHD Addictions and I am very grateful that they are here. There was no doctor that would prescribe me methadone. Other narcotics but not methadone.

The Result

- Most folks when they could not get medication took to buying pills on the street.
- Cost is $1 a mg. so a 15mg oxycodone is 15 dollars and would last 4-6 hours before withdraw symptoms and pain kicks in.
- Folks could not afford that but they could afford Heroin...not sure of cost but have been told it is much cheaper and lasts longer.
- Tada- We have an epidemic

A Different Way

- Maybe next time, the state and DEA should have doctors come into the office, go through the charts, offer people to rehab or treatment and get them started if no legitimate pain issues.
- Folks with legitimate pain issues should be referred, with an appointment, before discharging from that office.
- Just and idea for next time…

Why Treatment is Failing in this Area

- WCHD Addictions have been overwhelmed with new patients since Dr. Fox went out of business. They need some assistance from the powers that be in the state. They also need some direction from clinics that do it well, with good outcomes. I am going to list some issues that folks are having with treatment here and that are an obstacle to getting well. This is NOT out of malice of any kind.

Federal Guidelines from CSAT and SAMSHA

CSAT – Center for Substance Abuse Treatment

SAMHSA- Substance Abuse and Mental Health Treatment Services Administration

Federal Guidelines compared to Treatment Here

FEDERAL

- Each Treatment Facility should:
  - Sufficient Space and Adequate equipment for the provision of all services.
  - Is Clean and well maintained and is similar to and consistent with other treatment facilities for DIFFERENT medical and behavioral disorders.

HERE

Federal Guidelines to Treatment vs. Treatment Here

FEDERAL

- Provides services during hours that meet the needs of the overwhelming majority of patients, including hours before and/or after the traditional 8:00am to 5:00pm work day.

HERE

- Our Hours are:
- Monday thru Saturday
- 6:30am to 9:00am and you better not be late. If you show up at 9:01 you will NOT be getting your medication that day and if it is a Saturday No meds for 2 days.
- No Grace, No 3 strikes, nothing accepted from the addicts but perfection.
- THIS IS AN OBSTACLE TO TREATMENT

Federal Guidelines to Treatment vs. Treatment Here

FEDERAL

- CQI
- Develops and Implements periodic patient satisfaction surveys.
- Increasing Number of Patients who are Employed
- Consider community need and impact in selecting sites for programs
- Ensure the facility's appearance is clean and orderly and that the physical setting does not impede traffic flow.

HERE

- In 4 years I think I filled out 1 patient satisfaction survey and I never heard anything about what I said.
- I have witnessed patients being told that their job is not important or their college class is not as important as missing a class at the health department. Sometimes that is true and sometimes not. In fact having gainful employment increases self esteem and worth and all addiction stems from an unhealthy low self esteem or low self worth.

Carroll St is very busy early in Morning M-F. One person Has already been hit.

Federal Guidelines to Treatment vs. Treatment Here

FEDERAL

- Treatment facility has an adequate number of physicians, nurses, counselors, and other staff for the level of care provided and the number of patients enrolled in the program.

HERE

- Dr. Bautista is our Addictions physician. We are supposed to see him once a year. I do. Some do not. He is a good doctor, but overwhelmed. He sees all the Methadone/Addictions patients at WCHD. He sees patients at Lower Shore Clinic. He sees patients at Hudson Center and Warwick Addictions.
- He has way too many patients to do a thorough job.
- The same amount of nurses are on staff as when I started but there are probably, and I don't know the numbers, at least 250 more patients now.
- Male counselors have to come over to do the male urine tests and they do them all in one morning, so they don't have to come more than once a month. This causes major delays in an already lengthy process.
- There are times when we stand in line for more than an hour, a lot of times. No we cannot sit down without a note from the doctor. Why? Not enough room.., enough chairs...who knows. It is a not heated or air-conditioned , close quarters place. There are security issues directly related to putting patients in these circumstances. This is the only facility I have been in that has needed security inside or at all. Tampa had a city policeman that sat in the parking lot. I am sure Sheriff Mike Lewis would be happy to work with the clinic should they move to a better place.

Federal Guidelines to Treatment vs. Treatment Here

FEDERAL

- Full medical examination, including the results of serology and other tests, must be completed WITHIN 14 days FOLLOWING admission.
- For each new patient enrolled in a program, the initial dose of methadone shall not exceed 30 mgs. And the total dose for the first day shall not exceed 40 mg's
- Maintenance medication doses are sufficient to produce the desired response in the patient for the desired duration of time.
- Program wide dose caps or ceilings are contrary to the principle of individualized treatment and programs should NOT establish them. Programs should avoid establishing procedures or policies that hinder making patient dosage adjustments whenever indicated.
- Programs do not adjust medication doses to reinforce positive behavior or to punish negative behavior. For example, a patient's noncompliance with a treatment plan, including a positive toxicology screen, should not necessarily result in a decreased dosage. In fact, in certain circumstances this may indicate a need for an increased dosage.

HERE

- WCHD states this must be done before treatment even starts. This is an obstacle to treatment. It takes so long to get started, they give up before they begin.
- They start us at 25mg and we can go up every Friday, if they say so, 5mg. Starting at 60mg.s you must get your blood drawn. That's fine, but this is the process which can take up to 2 weeks to get 5mg.
  - Ask to go up on a Wednesday, must be Wednesday
  - Stand after you dose for 5 minutes the next week, M Thursday
  - Friday or Saturday morning, before you medicate, go get blood drawn
  - If the level was not too high, then you can go up 5mg on the following Friday
- This is done at 60, 80, 100, 110 mg's and I do not believe they allow anyone to go past 120mg's. , but I am not sure of that. I believe that is their unstated dose cap. I have seen patients struggling not to use but have to wait so long before going up they end up using. Then they have a positive toxicology and they will not let them go up because of that, which leads to the next point.
- This program does adjust medication to punish for non compliance and for positive toxicology screens. 6 months after I started I had severe neck pain. Went to ER finally, did an MRI and I had herniated a cervical disc. I made it clear I was a methadone patient and my dose. The dr. prescribed a steroid and 12 valium. Valium was never a drug I liked. I told them 3 different times that I was not allowed to take it, the clinic said it would kill me etc... I was assured that since it was a prescription and as long as I took the correct way I would be fine. I asked for any other muscle relaxer, but the doc said that was the best treatment. I still did not take for a day and a half out of fear of reprimand from clinic but I was hurting so badly I gave in. I took 10 of the 12 in a 10 day period. It took 2 months to come out of my system. The WCHD took me down 20 mg all together. I did inform them that I was given the prescription. I was told I shouldn't have taken it anyway, no matter what the doctor said, and that was a doctor that told me that sa

Federal Guidelines to Treatment vs. Treatment Here

FEDERAL

- Programs collect all urine or other toxicological specimens in a therapeutic context that suggests trust and respect and minimizes falsification. Reliance on direct observation, although necessary for some patients, is neither necessary nor appropriate for all patients.

HERE

- This is the door to one bathroom, clean right. They go in with everyone. They go in with me. I have never in 4 years been dirty for anything other than Marijuana and what I spoke of earlier. I have always been honest, but

They insist on Coming in with me Every time. The Reason I get is that We have to do Everyone the same. Really?? Individualized Treatment.

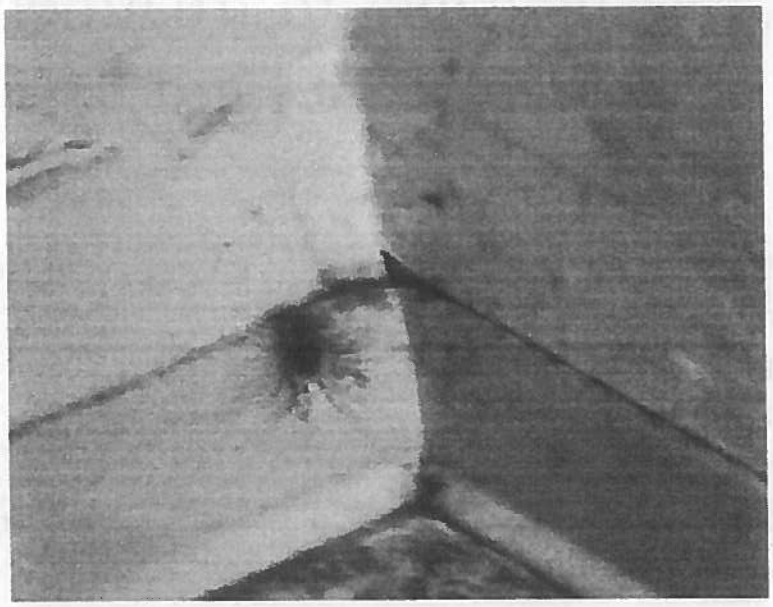
Federal Guidelines to Treatment vs. Treatment Here

FEDERAL

- Patients have the right to considerate, respectful, humane, and adequate care from all members of the staff, at all times, and under all circumstances. An environment of mutual respect is essential to maintain a quality environment.

HERE

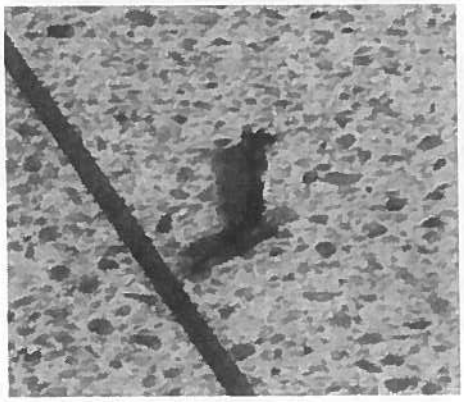
- Wow, so many things to say.
  - Most of the time, 90% of the time this is not true. I know the patients can be disruptive, offensive, loud, and rude. Staff is the professionals. Most all of the patients know me and they know I am a follower of Jesus Christ. I treat them all with kindness and respect and they give me the same back. If they use foul language in front of me, they apologize, etc..
  - When you treat folks like dogs, sometimes they bite. We've been told that we do not deserve a clean place, " I 've chased you people into worse places than this." Or, some of the hospital security will stop you if you are in PRMC visiting someone or getting a test done etc.. And say you don't belong here. Most of the hospital staff have a bad opinion of us. I worked there for 10 years and I know a lot of folks that work there.
  - I've been called, "hey you there" or heard nurses speak very rudely to patients. For the most part the nurses are very unhappy people and do not like us, for sure. I pray for them daily.
  - One time the WCHD guard that is there on Saturdays , very sarcastically says, "oh, yea no one in this line would ever lie..." And yes he is correct, we are all liars, all of us, even him, even them, even ya'll.

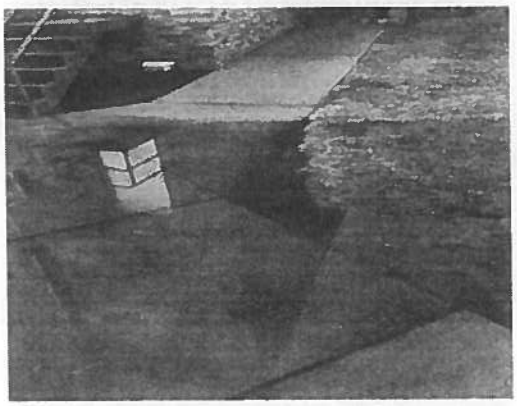


NICE CREATURE

We got to stand close together.

Chicken bone that was on floor for about a month.
Sidewalk that is a lake when it rains and the only way for us to get inside





Federal Guidelines to Treatment vs. Treatment Here

- The program has the responsibility to make every attempt to accommodate the patients desire to remain in opioid therapy at an alternative program before being discharged. Involuntary withdrawal is only as a sanction of the last resort.
- It is usually not a last resort.
- They do not make any attempt to get you into another program. My friend is being discharged and they never sat down with her at all. They told her at the dosing window by giving her 5mg. less. She had to call and ask questions. They would not even return her calls.

Final Observations that are an obstacle to treatment

- No grace for forgetting your methadone ID. NO ID, NO MEDICATION, NO EXCUSES.

They will not even let you substitute your Maryland State Issued ID and here is the reason they gave me:

"Other picture IDs would increase administrative work, slow down the clinic, and increase the risk of imposters attempting to fraudulently receive methadone."

I asked that if the patient happens to forget their methadone ID, could they use a Maryland State ID. I did not say all the time, I did not say any ID. So I guess your Maryland ID is not sufficient for your state run clinic? I have seen folks cry, beg, etc... to no avail. If they have time they can go to health department, get them to make a new one, pay $5 and come back to medication unit. Last week a young lady tried to do this and the nurse at the health department told her she did not have time, she would just have to do without her medication today.

Returning Sunday take home bottle on Monday. NO GRACE, NO Bottle, NO MEDICATION! Same thing, I have seen folks cry and beg and get angry etc... no way they will not dose you. I have forgotten mine once in 4 years and they would not dose me. I offered to bring to health department later today and if I did not they could not dose me tomorrow, but to no avail. Luckily I live close and my husband jumped out of the shower and brought to me.

And as I mentioned earlier, the late thing. NO GRACE ever!

I have asked my nurse about these things. I said you know the first thing most of the folks will do is go use drugs whey ya'll don't medicate them. She said" that is their choice". Really, is it a disease or a choice? What if they got bad dope and died, or over dosed because they forgot their ID....

They expect addicts to be 100% perfect, 100% of the time. I realize they want to teach responsibility, but you can have some grace rules, such as 3 strikes.

Trust me, the staff is not perfect either. There have been many mornings when the doors do not open exactly at 6:30am. My best friend got the wrong persons Sunday take home twice in 4 years, but they didn't even want her bottle back on those Mondays. They just said, " Oh we know but it was okay because it was the same dosage." Really?

Recently a fellow who was on 60mg was sent home with 100mg and was punished because he didn't bring it back..., an addict.

I understand mistakes, what I don't understand is perfection.

Children

- Many of the patients have children, young children. They cannot bring into the medication unit. It is not a good place for kids, granted, but most are single moms who do not have anyone to watch their child while they medicate. So, they bring them and ask other patients to watch them in the car, or they leave sleeping kids locked in car. Its cold and in the summer if they get out of car and run around parking lot, someone is going to get hurt. I have been to 3 other facilities in the country. They all looked like a regular doctors office. They had waiting rooms, heat, AC, and they accommodated children. They had chairs across from dosing windows for kids to sit in while parent dosed. Even if we move, I do not think they will change this rule. Here is the response I got to this issue:
  - "We have concerns about liability issues for us and PRMC; exposure of children to undesirable language and behavior, potential exposure of children to infectious diseases; potential disruptive behavior by the children; and potential for mistakes in dosing due to distractions related to the children."

  Okay, let me respond- Liability issues? But there is no liability issues with them being in parking lot , running around, with relative strangers in the cold and heat? Okay then. As far as language and behavior, well don't take your children to a ball game or any place where adults can drink. Infectious diseases?- children can go into the ICU unit now, but we are more of a hazard?

  And I am certainly glad that me and my staff were able to draw blood from adults with children around, or from children without making huge mistakes. This doesn't speak well of the staffs skills in their jobs and what is their excuse for the mistake they make now? Silliness

Closing

- I am grateful the clinic is there. They need some assistance. They need to find a new facility, away from PRMC and out from under PRMC. There are many methadone clinics that operate without a hospital to store their medication and for security. The clinic pays PRMC $45,000 a year. This includes storage of methadone and the security guard M-Friday 630-9. I have looked at some commercial properties in the area that would accommodate. They are much bigger and half the cost. WCHD Addictions could use the money they save and buy a safe and whomever they purchase the methadone from is responsible for its transport to facility. PRMC does not want us there, but they do not want to give up the $$$.
- I asked the staff to call one of the private clinics or public and see how they do it without the hospital pharmacy storage and security. And it is just storage, not the meds themselves. They looked at me like I was crazy and said they would never. " A haughty spirit comes before a fall."
- I am in the middle of a grievance process for these issues. Not getting very far though. They want folks to come to them, but they are either afraid or they are apathetic. It never does any good.. It is a tough road, but Jesus is on my side and He wont give up, even when I want to. Folks are starting to detox themselves even if they end up using again just because they are tired of being treated this way.
- HELP,HELP,HELP
- I have called the methadone authority to no avail, they keep changing who is in charge. I keep getting the run around. HELP HELP
- Soon there will be competition from private clinics and WCHD Addictions will lose most of their patient.

Heroin Task Force Testimony

Introduce self: John Winslow

- Designee of Dorchester County Health Officer, Roger Harrell
    - DCAP Director
    - Dri-Dock Founder & Oversight
    - Coordinator of NCADD-MD's Recovery Leadership Program
    - Person in Long-Term Recovery- continuously abstinent over 39 years
        - Daughter, Sherry- 3 years in full recovery
    - As a result of **all** the above… I've got a great deal of "skin in the game"!

In Dorchester County we see the numbers of young people from all walks of life seeking treatment for heroin & opioid dependence **skyrocketing**. So far, we've "dodged the bullet" in terms of avoiding having had a significant number of fatal overdoses, but we can't be misled by this data. The substance use disorder problem in Dorchester is bewilderingly profound here as it is in all municipalities, towns, cities, and rural areas here in Maryland - as it is across our entire nation!

*Successfully resolving this Heroin and Opioid problem in our communities through the effort of any **ONE** entity, agency, Task Force, organization or institution is impossible. This **MUST** be a **WE** effort… as my sponsor in my early recovery used to proclaim…* ***"WE can do together what NONE of can do alone"!***

- *To that end… we need problem-solving input from **everyone**.*
    - *There are those amongst us that may be highly critical of numerous aspects of "**the system**".*
        - ***We need to hear your voice**. We need your critical comments- but I must emphasize the importance of voicing your criticism CONSTRUCTIVELY! **This is NOT the time to be throwing rocks at one-another!***
- *We also need to hear from the **champions of recovery**- from those seeking recovery, those successfully in recovery, and from the family members - both those with loved-one in active addiction, in treatment and/or recovery, and from those who have lost their loved-ones from this insidious illness.*

In order to successfully resolve this crisis we need EVERYONE'S help and we need to address the **FULL continuum** of Substance Use Disorder services: **Prevention, Intervention, Treatment, & Recovery.**

To that end, I respectfully submit the following recommendations:

Prevention:

There are three recognized levels of prevention:

Primary Prevention (Attempts to avoid substance use or abuse before it has a chance to occur.):

Secondary Prevention (for those "at risk" for problems with alcohol & other drugs of addiction): and

Tertiary Prevention (The goals are to terminate use of the substance and thus avoid further deterioration in the person's functioning - or to support maintaining/sustaining ongoing recovery efforts):

With Primary Prevention (*Attempts to avoid substance use or abuse before it has a chance to occur.*):

- We need to: Increase overall efforts to change our culture:
  - Our society (and that of many countries worldwide) promote a climate of pleasure and comfort *over* health and wellbeing! From the promotion of alcohol at sporting events to repeated daily expose encouraging "instant relief" on television, every one of us (children, youth, adults, and the elderly) are encouraged to "go for the gusto" or seek the "easier, softer way". **Look where it's gotten us!**
- We need to: Establish legislation to tighten controls on "inappropriate doctor prescribing"
- We need to: Explore the feasibility of holding pharmaceutical companies accountable for excessive promotion of dangerous, highly addictive opioid-based medications – since they have contributed so significantly to the problem, we should insist they financially contribute to addressing the solution!

- We need to: Educate the public re: (example) Search Institute's "**40 Developmental Assets**" – basic building blocks to help youth succeed and avoid unhealthy behaviors. Everyone can be an "Asset Builder"
- We need to: Implement "**Environmental Prevention Strategies**- taking a broad approach to prevention efforts:
    - *Grounded in the field of public health, which emphasizes the broader physical, social, cultural and institutional forces that contribute to the problems that coalitions address,* ***environmental strategies*** *offer well-accepted prevention approaches that coalitions use to change the context (environment) in which substance use disorders can occur.*
        - *Environmental strategies incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. Coalitions should select strategies that lead to long-term outcomes. *Educating the public at large regarding Opioid misuse, increasing fines for underage drinking, moving tobacco products behind the counter, and not selling cold, single-serving containers of beer in convenience are all examples of environmental strategies.*

Secondary Prevention (*for those "at risk" for problems with alcohol & other drugs of addiction*):

- We need to: offer Intensive substance use-related education for "at-risk" and "high-risk" individuals such as those charged with drug-related offenses or children/adolescents of addicted parents.

Tertiary Prevention (*The goals are to terminate use of the substance and thus avoid further deterioration in the person's functioning* ***or*** *to support maintaining/sustaining ongoing recovery efforts*):

- We need to: Promote Recovery High Schools in Maryland.
    - It is tragic for a young person to be so deep in her/his addiction that they need an inpatient treatment experience, begin to get their lives turned-around only to come back to the community in which they were using

and have to return to the same high school where their "getting high" buddies all hung out! How can we expect them to remain abstinent and recovery in these circumstances?

- We need to: Promote the establishment/expansion of Collegiate Recovery Centers (CRC's).
    - There are currently very few CRC's in the nation. *Maryland only has one fledgling CRC to my knowledge- located at Loyola College.*
- We need to: Promote the expansion of Young People in Recovery (YPR) chapters across the state.
- We need to: Expand places where youth in recovery can hang-out and socialize with out all the temptations to use.
- We need to: Continue with expansion of Narcan availability throughout the community, Law Enforcement, Emergency Management Services, other First Responders and anyone & everyone potentially touched by Opioid addiction. *we are in the process of not only providing Narcan availability to our first responders and law enforcement in Dorchester county, but also family, friends, and loved ones – as well as training our addictions treatment staff and Recovery Community Center peer staff in this life-saving method.
- We need to: Look for opportunities to introduce Vivitrol (long-lasting injectable Naltrexone- an antagonist medication that blocks/prevents the "high" from opioids while simultaneously reducing cravings) at every opportunity, especially in jails, prisons, and other institutions prior to their returning to the community
    - *Research shows that this is the most vulnerable population to fatal overdoses due to a reduction in tolerance as a result of imposed abstinence*

Intervention:

We need to insure that adequate funding is available to support the following essential services:

- Drug Courts
- Traditional Courtrooms- *educated Judges & Masters can use the courtroom and an ideal opportunity to refer to treatment as an alternative to incarceration*
- DJS
- P&P
- Private Interventions
- Mobile Crisis Teams
- Crisis Intervention Teams
- *__Note__: All the above need availability of peer involvement- (*persons with lived experience*) – we **MUST** grow our peer workforce!

In terms of Treatment efforts:

We need to offer the following:

- Simply put: We need adequate funding in order to offer a **full range of treatment services** as medically indicated by ASAM criteria

In terms of Recovery efforts:

We need to offer the following:

- We need to: Support **ALL** pathways to recovery
- We need to: Establish and maintain funding support for RCC's (including Colligate Recovery Centers-CRC's) around the state
    - *Mention Dri-Dock
    - **Build a protective recovery community environment –** *our RCC's can serve as a hub around which we can offer safe, sober housing, schools, playgrounds, places of worship, where people and families can live in the absence of constant exposure to the people, places, and things that supported and contributed to their active addictions*
- We need to: establish more safe Sober housing for men, women, and families seeking to maintain ongoing recovery efforts

    - We need to: Continue to grow our Peer workforce: *this very cost-effective strategy needs to be embedded in a wide variety of settings beyond our Recovery Community Centers such as…*
        - Emergency Rooms
        - Treatment centers
        - Detentions centers
        - Working with local police
        - Working with Mobile Crisis Teams
- We need to: build and strengthen all of our Recovery Supports – housing, transportation, employment, education

Finally, I wish to thank the governor, the lieutenant-governor, members of the Task Force, and all the officials, providers, family members, and concerned citizens for the time and effort you are taking to address this most alarming public health and safety crisis!

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Worcester County Talking Points-Heroin and Opioid Emergency Task Force
June 10, 2015
Dr. Andrea Mathias, Deputy Health Officer

Public Health Perspectives

The Opioid Overdose Fatality Review Team reviews OCME data for Opioid related deaths in Worcester County.

- **In 2014 - 78.5%** of all overdose deaths in Worcester were opioid related.
- The number of opioid related deaths **doubled** from 2013 to 2014 (from 6 to **14** deaths)
- Deaths from both prescription opioids and "street" opioids (heroin and cocaine) continue to increase in Worcester between 2011 and 2014. Worcester County has **not** seen the downward trend in prescription opioid deaths that is reported statewide.
- In Worcester, the absolute number of deaths related to opioids may seem small, but crude opioid overdose death rates for Worcester approaches that of other seriously affected areas like Baltimore County.
- Our Addictions treatment providers and Law enforcement see an increase in heroin trafficking and use, specifically with a trend for IV use as the preferred method.
- The CDC recently released a public health advisory about rising rates of HIV and Hepatitis C infections in locations where IV heroin use escalates. Rural communities are highlighted as especially vulnerable. We are concerned that Worcester is at risk for this public health crisis.

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Worcester County Health Department
Jennifer LaMade, Director, Planning, Quality and Core Services

If you ever doubted the power and hold heroin imposes on people's lives, consider this firsthand account from a 19 year old in Connecticut.

Mike McCrorken says he began smoking marijuana at age 12 and graduated to heroin by 14. His mother and stepfather often injected drugs with him.

"I tried to get help so many times growing up," said McCrorken, of New Haven, Conn. "Getting into detox was always difficult because there were never any beds available."

The wait for a spot in a detoxification program ranged from days to weeks, McCrorken says. He was never able to abstain from drugs that long "If I had to wait, without a doubt, I was getting high," he said.

McCrorken finally got into treatment when he was 19, after the death of his stepfather. He and his mother heard his stepfather collapse behind a locked bathroom door. McCrorken kicked the door down and found his stepfather on the floor, bleeding and unconscious from a heroin overdose.

"Before we called the police," McCrorken said, "we did the drugs left in his pocket."

- Only 11% of the 22.7 million Americans who needed drug or alcohol treatment in 2013 actually got it, according to the Substance Abuse and Mental Health Services Administration. Some of those who went without care did so by choice. But at least 316,000 tried and failed to get treatment.

- Every dollar invested saves $4-$7 in less drug-related crime, criminal justice courts and thefts, according to the National Institute on Drug Abuse. While one year of methadone costs $4,700, a year in prison costs $18,400.

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Impact of opioids in the community

- Worcester County has a Crude Death Rate for total intoxication deaths that is higher than the state average {Worcester 12.8 per 100,000: Maryland 11.9 per 100,000 population}, (The Maryland DHMH Drug and Alcohol Intoxication Deaths Report from 2007-2011). In 2015 thus far, Worcester County has had 6 unintentional deaths from opioids. This matches the total number of deaths related to opioids for 2014.

- The age-adjusted data show that Worcester has an even greater disparity in Crude Death Rate for total intoxication deaths, compared with the state average {14.5 deaths per 100,000 population in Worcester vs. 11.5 per 100,000 population in Maryland}. 65% of all Intoxication related deaths (28 of 43) in Worcester County between 2007 and 2011 were opioid related. This compares to 77% statewide. However, 48% of total (21/43) intoxication deaths in Worcester County were related to *prescription* opioids whereas 41% (1427/3450) of total intoxication deaths were related to prescription opioids statewide.

Emerging Public Health Trends:

- **Hepatitis C infections have increased 150 percent** in the United States over the last four years, illustrated recently by an HIV/hepatitis C outbreak in a rural Indiana county. Linked to intravenous drug use, hepatitis C infections are on the rise nationally. Indiana's drug-fueled outbreak — 153 confirmed cases — prompted the federal Centers for Disease Control and Prevention to issue a health advisory alerting states, health departments and doctors nationwide to be on the lookout for clusters of HIV and hepatitis C among intravenous drug users and take steps to prevent them.

Existing Services

- Behavioral Health Intake Team – Snow Hill Walk In hours Monday thru Friday 8am to 9:30am, scheduled appointments also available.
- Individual and Group services available at all sites, IOP services 3 days a week at WACS. Specialty Groups also available in addition to our traditional groups. Examples include; Dual, Women's, Transition.

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- Having Peer Support Specialist located in the Emergency Departments and/or walk in facilities.
- Stigma Training around substance use and treatment
- Providing Naloxone Training to inmates while incarcerated. High risk population of overdosing after being released.
- Hepatitis C screening/treatment
- Additional funding/facilities needed for detox services, especially the ability to offer residential detox when needed for opiate treatment.
- Routine CRISP checks on all clients who enter treatment

Wicomico State's Attorney's Office

A Plan for Maryland

Reducing Heroin Deaths Through Rapid Response

There was an 18% increase in the number of heroin related deaths between 2012 and 2013, and an 88% increase since 2011. There were 464 deaths in 2013, compared with 392 in 2012 and 247 in 2011, according to figures by Maryland's Department of Health and Mental Hygiene. Effectively addressing this deadly problem will require multiple strategies as highlighted in the 2013 Maryland Opioid Overdose Prevention Plan. This proposal provides sorely needed treatment resources where and when they are most needed.

PROPOSAL

The State of Maryland will create a dedicated funding source to provide access to treatment on demand with fiscal management of treatment dollars for cost-effectiveness and cost-efficiency. The opiate reduction initiative proposed below will provide the ability for the target population to obtain immediate screening, referral, and treatment placement through an "Access Center" that will be clinically staffed and available 24 hours, 7 days per week. **Many community and social services required are already available, this proposes an expansion of resources, treatment on demand, and funding that follows each client's treatment and care.**

COST

Total cost per individual averages $3,000. - $3,500.

Key points of this proposal include:

1. **Identification of targeted population, aggressive case finding aimed at engaging the chronic group that causes a disproportionate amount of the crime, recidivism, public resource use, etc.**
2. Offer treatment on demand.
3. Call center staffed 24/7 allowing immediate screening and referral for treatment.
4. Increased capacity of Mobile Health Vehicles.
5. Comprehensive assessment to determine clinically appropriate level of care.
6. Care coordination across a continuum of services.
7. MAP follow-up post treatment during the first 12 to 15 months in recovery.

Identification of the target population will be from several sources contacting the Access Center: (1) Naloxone (Narcan) first responders, (2) emergency departments, urgent care centers, and FQHCs trained in Screening, Brief Intervention, Referral to Treatment (SBIRT), (3) criminal justice system, drug court, parole, probation, (4) Maryland Poison Control Center, (6) the general public seeking treatment.

Primary Responsibilities of the Treatment on Demand Access Center

- Maintain a toll-free line to callers that will provide information, screening, and treatment referral 24 hours per day, 7 days per week.
- All calls received are by licensed/certified clinicians prepared to conduct screenings, review assessments, determine immediate need for possible crisis intervention, etc.
- Based on information collected during the screenings, treatment providers will have been identified to provide assessment and treatment as a choice to the person seeking immediate services.
- Ongoing Care Coordination and utilization review by Care Coordinators of client population flowing through the Access Center, Mobile Health Vehicles, and treatment providers.
- Care Coordination of referral flow to and from treatment providers and Mobile Health Vehicles.

Comprehensive Assessment by the Treatment Provider

- Ensure uniform screening and assessment of substance abuse and/or mental health severity (comprehensive assessment tool to obtain the strengths/needs of the population, *The ASAM Criteria, DSM*) by designated treatment providers across a variety of treatment modalities.

Care Coordination by the Access Center

- Client advocacy and linkages, ensuring all immediate needs/safety needs are identified and addressed.
- Decrease fragmentation of treatment services among providers offering various levels of care while increasing access to medication-assisted treatment and other modalities.
- Maintain and utilize a robust network of addiction and/or co-occurring mental health treatment services integrated with other social services.
- **After initial engagement, Care Coordinators will make an intense effort to place them in clinically appropriate ongoing treatment -- not just stabilize them on medication-assisted therapy.**
- Ongoing utilization review with the treatment providers and facilitation of client movement along the treatment continuum.
- Comprehensive outreach to ensure client engagement and retention.
- Development of strong relationships with community resources.

Benefits of Care Coordination: **After initial engagement and stabilization (primary treatment), the Care Coordinator will continue to case manage each client into early recovery but will also coordinate the efficient delivery of relevant social and community services to augment recovery -- job training, housing, transport to 12 step, child care, etc. Experience in New Jersey shows huge social and financial benefits of this approach.**

MAP Recovery Support Post Discharge from Treatment:

- **Provides weekly phone support during first 15 months of recovery with a MAP Specialist. These Specialists are all 3 or more years into their own long-term recovery, which is a powerful resource.**
- Developed algorithm-driven software provides a robust collection of data to effectively track client progress and outcomes over time.
- Seeks early warning signs of relapse and allows for intervention before relapse happens.
- MAP Specialists engage the entire family to provide support and guidance in early recovery.

Ensuring Successful Outcomes of the Access Center by:

- Utilizing a demonstrated model of care coordination during the treatment phase followed by MAP Recovery support,
- Improving coordination of community partners who offer detoxification/residential programs and medication-assisted treatment modalities,
- Permitting mobile vehicles to have screeners on site who will call the Access Center with the client present to offer treatment on demand,
- Developing and coordinating community based recovery support services, including peer recovery centers,
- Providing aggressive outreach to populations at high risk of overdose, while also promoting naloxone distribution and education with treatment on demand,
- Increasing public awareness of the Access Center through community meetings, educational programs, viral marketing campaign and advertising in popular media outlets, including social media, and
- Utilizing a data system that captures assessment data/results, treatment placement with level of care, length of stay, linkages, participation rates, and outcomes. **Additional outcome measure would be available secondary public databases to monitor efficacy of the effort.**

Our story: A call for help, A MISSION of HOPE

Good afternoon. Our personal story is just one of many, unfortunately. Many of our stories, vary but share similar paths and frustrations. The heartache of the families and addicts has become an all too familiar reality. The stigma, label, and lack of resources has left families and addicts with a sense of despair.

Our son, Jacob was raised with morals, values, and a strong sense of work ethic. Jacob was a role model for other youth, well-educated, and contributing member of society. He is musically gifted, bilingual, intelligent young man. Many of our friends had sons, naming them after Jacob because of his character. At the age of 18, life for our family, began to change. We returned to the eastern shore, with the hope of our son starting college and daughter beginning kindergarten and for the strong sense of connectedness we missed living in the city. We longed to be with family and friends. However, that dream would soon turn into a living nightmare, leading to eight years of struggle, loss of self-esteem, purpose, and many legal troubles.

Often times, those struggling with addiction lose their sense of self to substance use and abuse. Drugs strip our loves ones and our community of young people who now live with their choices. Our loved ones did not set out on the path of destruction. However, the consequences are devastating, leaving families desperate for help, resources, and hope. They no longer even recognize their loved ones and when faced with the realization we need help, we are met with resistance and despair.

When I realized Jacob needed help, we were met with little options unless the drug of choice was alcohol. Sadly, heroin and opiate addiction is not viewed as life threatening by medical personnel. Thus, addicts are left to detox on their own. The fear of withdrawal is overwhelming.... with just "one more time" always at the forefront of the addicts mind. Without health insurance, the battle is further heightened and option diminished. Eventually, I was able to get Jacob admitted to Walden Sierra, where he stayed 10 days, only to return home with an insatiable urge to use, leading to several legal charges, resulting in incarceration, without available treatment or alternatives such as drug court, simply because of the address he used at the time of incarceration was in a different county of his impending charges. After serving 14 months, with 22 years suspended, Jacob was released without a transitional plan, needs assessment, or resources for help. Our community failed him. Society views our loves ones as a menace, "fiends", "lost souls", a drain to resources.

The fact remains that heroin/opiate addiction is not on the rise to becoming an epidemic, it already is an epidemic. Relapse is certain unless we, as a community, join together, removing the stigma, and provide a sense of HOPE. Our community lacks awareness and is quick to point fingers. There is more awareness and resources dedicated to recycling than on addiction and recovery. Education without action will not change this epidemic. We need resources, community involvement without shame and judgement, alternatives verses incarceration.

Unfortunately, my experience with heroin and opiates, extends beyond personal, but also professional. As a social worker, I have met with many families and addicts. The struggle is real. The denial worse. The hope diminished. Addicts on probation cannot even confide with their probation/parole agent they may be struggling for fear of being violated, with no alternative but to serve the remaining portion of their sentence.

There is a gap of disparity between juvenile offenders and adult offenders. Juveniles can be a ward of the state until the age of 21 and may not be released from commitment without verifiable, viable stable living arrangements. They are provided treatment, if necessary, and transitional plans. Additionally, many addictions have co-occurring diagnosis, impacting them psychologically and physically, long-term. Most do not have medical or dental insurance. Heroin and opiates causes internal and external effects, causing dry mouth, leading to decay of their teeth. An addict's once beautiful smile, is destroyed. Furthermore, this disparity continues with the varying available services available at detention centers. Some facilities provide NA meetings, mental health, whereas smaller detention centers are left without any resources to assist inmates battling addiction. The needs are many, the alternatives limited.

Our story, is one of many. The addict is not "in the bad spots of town" but everyone, crossing every socioeconomic status. The face of addiction is your loved one, your neighbor, your coworker. As I close, I would like to read you a small portion of the letter I received recently from Jacob. "I can't wait to come home. Lately, I find myself more and more wanting a family of my own....." He dreams of having a daughter that cannot wait to see her father and tell her about her day. Yet, "I feel it's so far out of reach. Almost intangible. I'm a tainted, tattooed, convict, and an addict..... Wanna a family?" Our loved ones, our community, our state, our nation needs resources to make drastic, immediate call to action. We need HOPE.

Thank you.

Testimony/June 10

Maryland's Heroin and Opioid Emergency Task Force

I would like to thank the Lt. Governor for chairing this task force on this important issue and also thank the members of the task force for their hard work and commitment to this cause.

My name is Leslie Brown and I am President and CEO of Hudson Health Services in Salisbury. We operate an inpatient facility, day treatment and 3 halfway houses, one for pregnant women and children and three sober living houses. We treat over 1500 patients per year and have 70 employees.

For more than ten years, Hudson Health Services has received reimbursement from managed care funds for inpatient detoxification for Medicaid patients. Inpatient detoxification is a medically monitored process performed in a free-standing specialty facility, with staff that includes a medical director, psychiatrist, registered nurses and clinicians including 24 hour care.

In January of 2014, Maryland Medicaid expansion occurred and our waiting list went from a handful of patients needing detoxification and treatment to 50-100 plus patients. At that time, the percentage of those suffering from opioids was around 80%.

A year later In January of 2015, the doors were shut on the patients when we were informed that the Medicaid patient would not receive inpatient care - only services at an outpatient level. The Medicaid patient who needs detoxification must go to a hospital for services that cost 4 times the amount of an inpatient detox at a facility like ours. The hospitals are not prepared for the onslaught of patients and many patients who are told that they cannot get services at our facility will refuse to go to the hospital and continue to use or overdose. From the data we receive, up to 90% of the patients needing detoxification are using opioids.

All inpatient facilities in Maryland are in jeopardy as a result of this decision by the State of Maryland and many will subsequently close. The communities, families and local employers have relied on these centers for care and consultation on the many facets of addiction.

The State of Maryland is tearing down a system that works and will eventually force residential treatment centers to close. The domino effect of this change will surely turn the treatment of addiction in the State of Maryland into a state of chaos and cost the taxpayers millions of dollars.

Please consider overturning this ruling or if it is not feasible due to a federal law, please consider putting supplemental state dollars into detoxification for treatment facilities.

Lastly, I would be remiss if I did not acknowledge the importance of all facets of care in treating addiction. Addicts must be treated with an array of services that are matched to the severity of their condition or need and their treatment must be sustained beyond one limited episode.

This includes;

- The integration of primary care with addiction services
- Addiction specialists in hospitals
- Accredited evidenced based treatment facilities and outpatient centers
- Extended engagement services or centers with recovery specialists and coaches including recovery housing
- Access to Tele-health and psychiatry in rural areas
- Prevention that engages schools, parents and the community

Treatment, prevention, early intervention, research and innovation must be addressed in a collaborative and innovative way.

The impact of addiction in our state has been brought to the for-front of public attention because of the dramatic increase in opioid use and subsequent overdoses. Together we can build a system of care that addresses the chronic nature of addiction and lifelong management.

Thank you for your time.

MARYLAND

Heroin Taskforce -GOV- <heroin.taskforce@maryland.gov>

graphs on maternal and neonatal substance abuse

1 message

Hitchens, Diane <DIANE.HITCHENS@peninsula.org> Tue, Jun 9, 2015 at 6:45 PM
To: "heroin.taskforce@maryland.gov" <heroin.taskforce@maryland.gov>

Good Evening,

Thanks for giving me an opportunity to share our stories at PRMC tomorrow. I have included a few graphs that you may find interesting. See you tomorrow.

Thanks

Diane

Diane Hitchens, BSN RN

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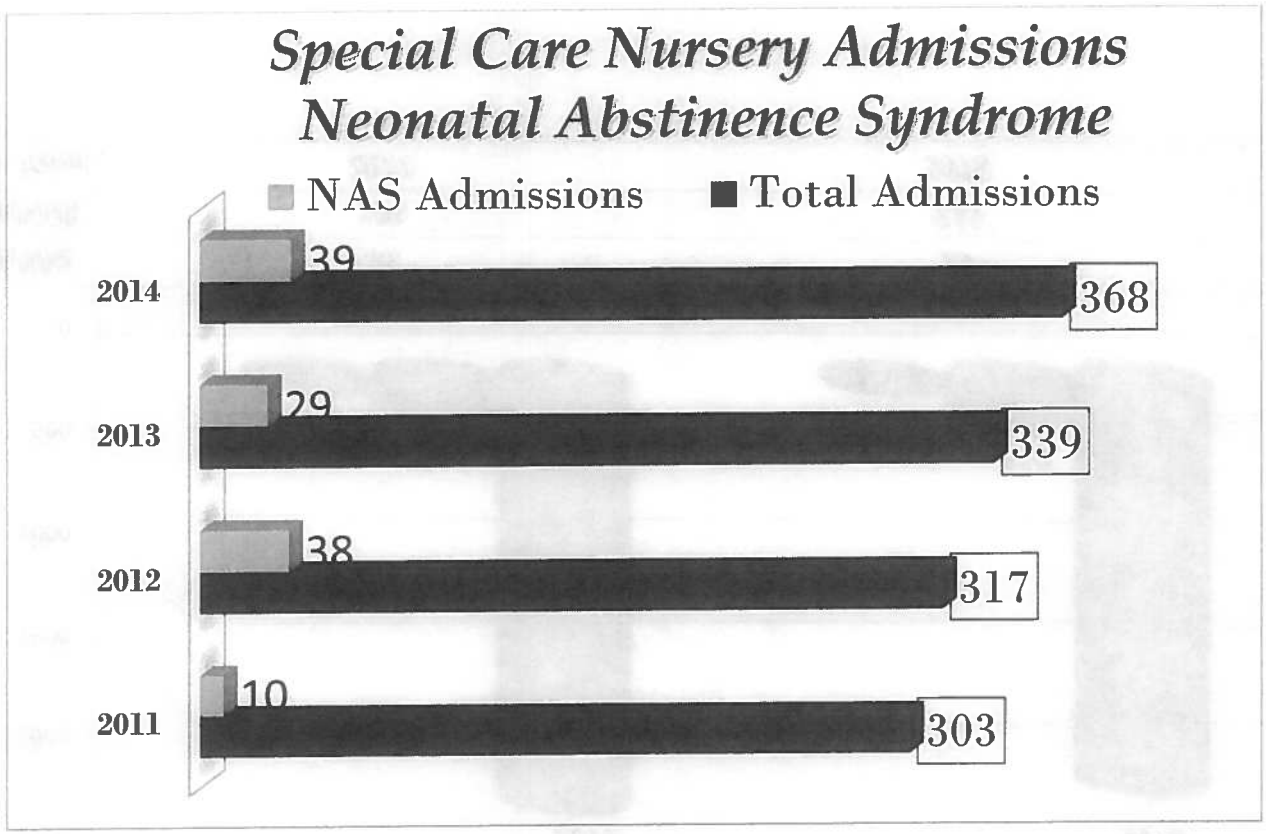
PENINSULA REGIONAL MEDICAL CENTER

LIVE WELL

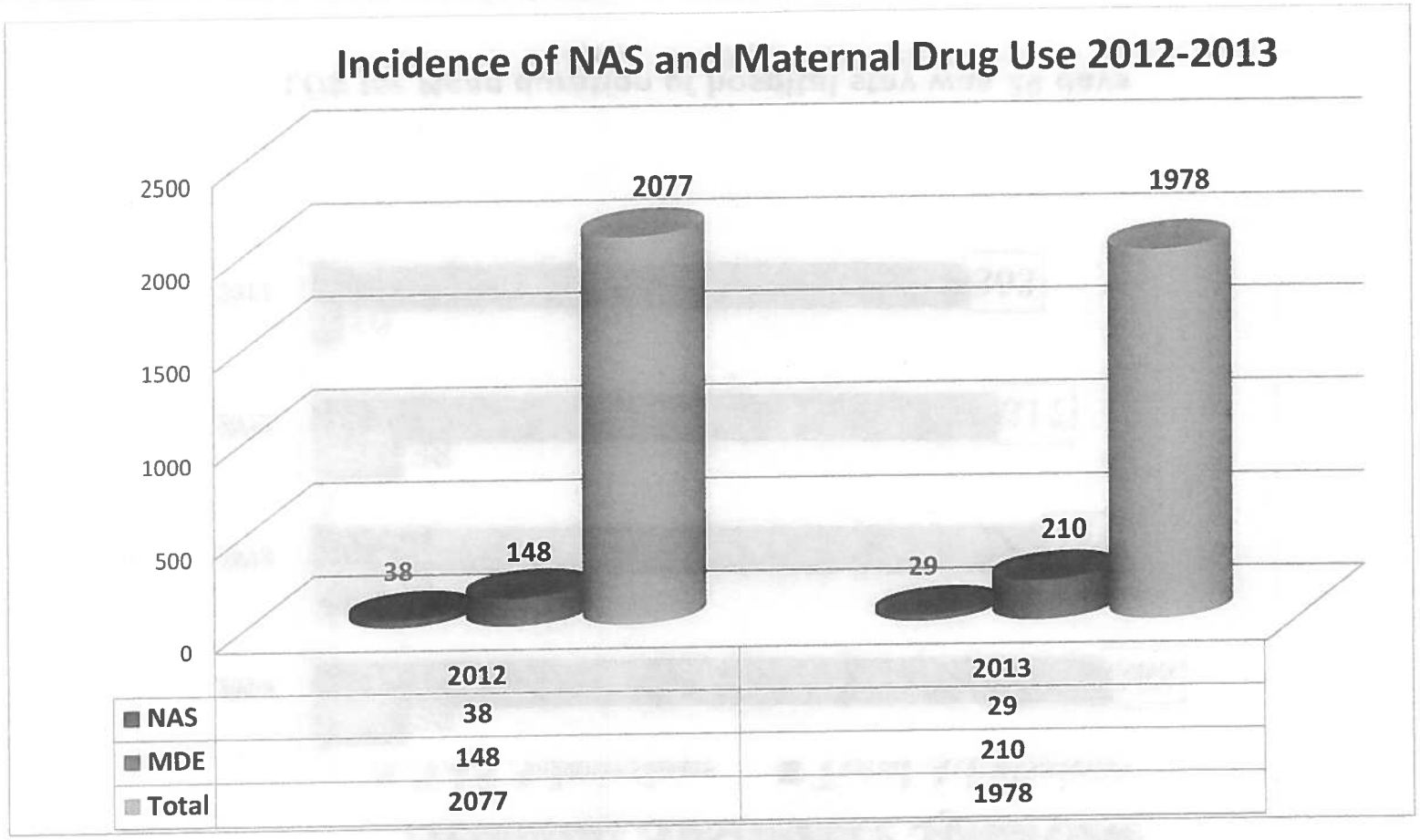
NAS Summit JUNE 10.docx

PRMC Stats



LOS for Mean duration of hospital stay was 29 days

Incidence of Neonatal Abstinence Syndrome and Maternal Drug Use @ PRMC



Current NAS Research Study 2012 and 2013

The total number of newborn deliveries in 2012 and 2013 were 4055.

358 mothers were identified with antepartum narcotic use (88.2/1000).

In the 2-year period, 67 neonates were admitted to SCN with a diagnosis of NAS (16.5/1000)

Overall 17% of treated infants required second line treatment including either phenobarbital or clonidine when the opiate did not adequately control withdrawal signs.

Incidence of low birth weight (LBW) was 11% Preterm (PT) birth was 22.1%

Maternal drug abuse included mainly:

- Marijuana 83%,
- Cocaine 17%,
- Methadone 6.9%,
- Hydrocodone/Oxycodone (5.8%),
- Subutex / Suboxone 5.5%,
- Benzodiazepines 4.1%,
- Heroin 1.7%.

Approximately 55.3 % of mothers reported using more than one drug

Average length of stay: Subutex/suboxone and were 23.6 days, Methadone exposure 31.4 days

PRMC versus National

Key Characteristic \ Year	2012	2013	2013 (National)
Number of Deliveries	2077	1978	
Maternal Drug Use	145 (69.8/1000)	210 (100.6/1000)	5.6 /1000
NAS	38 (18.2/1000)	29 (14.6/1000)	3.39/1000
Pharmacological Treatment (%)	16.5	10.9	
Length of Stay (Day)	27.5	30.8	16
Low Birth Weight (%)	11	11.4	8 (CDC)
Prematurity (%)	24.8	19.5	11.4

Recommendation

- To have private rooms available in SCN to provide a quiet room and accommodations for the mother to stay with the newborn.
- Standard method of drug testing and standard results across Maryland.
- To offer a compassionate withdrawal treatment for infants born with NAS and their mothers in a family friendly facility.
- These services should include a multidisciplinary team with the focus on substance free lifestyle. I believe that the substance abuse recovery rates will dramatically increase if this type of facility was available.

I was born and raised on the Eastern Shore, educated, a home owner at 24 and have owned a local business for the last 6 years. I was also addicted to heroin. I am the LAST person anyone would have expected to be called a heroin addict. I certainly never considered that an option when I was mapping out my 5 year plan. I have 3 children - I worked from home so I was actively involved in their schools (even the president of the PTA) and able to be with them 24/7. I don't want to blame shift regarding my addiction but I will say the driving force behind it's progression was a desire to be a "good" mother...I was diagnosed at a young age with rheumatoid arthritis and prescribed pain medication. Taking that medicine let me run circles around my children and accomplish things that my pain and subsequent depression had hindered (and, of course, those undone things made me feel like a failure). I could finally be the supermom that I had read about for 12 years in my Parents magazine subscription. It's embarrassing to say I didn't realize until I was addicted that I WAS addicted. I immediately sought help and was faced with many delays and closed doors. A six month wait to get into a doctor on the shore...unsympathetic doctors that will choose "if they like you" enough to treat you and of course the stigma (and shame) of admitting to anyone that you have an opiate addiction. It was EASIER to buy the medicine (suboxone) on the street than to see a legit doctor. Of course, that lasted for about eight months until my suppliers were let go from their maintenance programs for a failed urinalysis for marijuana, and loss of health insurance, respectively. Back to square one and sicker than I had been from the pill withdrawal. And why they call it sick I'll never understand...Sick has absolutely nothing to do with that slow, miserable death - where, in fact, death seems almost a viable, or sometimes better, option than that suffering. Sick implies you can still function and I promise that I could do NOTHING "sick", certainly not adequately care for three children. Sick implies that there is some remedy as opposed to adding snow to the downward spiraling snowball. Sick implies that there's a cure. It was impossible for me to even seek help when I wasn't "well".

People also have a misconception about opiates, that they leave you nodded out, itching and drooling in some corner. That was never my experience nor many of the addicts I've encountered. Long after the short-lived stage where the opiates provided a euphoric feeling (over the first month or two of the pain meds), the energy and loss of pain remained. Alas, I can not fault anyone their opinion as it was one I held UNTIL I did it myself. I will say that I am unique (but certainly not better than anyone) in that I regulated myself and my consumption to the same amount three times a day – just like my medication...we call it not getting high but getting by. Which is the case with almost all the people I know addicted to pills or heroin. We're not going to bars getting falling down drunk or even having a good time. We are maintaining a habit to feel "normal", to be able to get out of bed or off the floor and deal with kids, a job, our life. I was able to 'maintain' my normal for longer than most but am sadly suffering the repercussions of my addiction now that I am sober, including a recent incarceration in which, ironically enough, I ran into another PTA mom whom had been on the board with me 6 years ago when I first started, also incarcerated for heroin. Of course, I knew that there was an epidemic of heroin addiction blossoming in Maryland, and I've seen dozens of other successful people (lawyers, realtors, nurses) that are addicted to opiates, but seeing her there really hit it home for me. I am not the anomaly I thought I was. Other "good" people who are dedicated, loving parents – hard-working, altruistic and actively involved in their communities are falling prey to this rapidly spreading disease. For instance, I was very involved in Midshore Council on Domestic Violence and over the course of years let several women and their children move in my home cost-free, helped them learn to budget, balance check books and find stable homes. I hosted an annual Easter Egg Hunt for my entire town. I encourage my children to participate in charitable activities and demonstrate empathy and generosity, sometimes to a fault. You would think I could have banked at least a little good karma for this...and perhaps I did, in that I'm still sitting here and able to write you. That doesn't stop me from questioning how something like this could happen to me, how I could have been so naive or how I let it go this far. It was that introspection, however, that highlighted the faults in a system that seemed to work against

me...
Seeking help and meeting delays, being turned away and engaging with un-knowledgeable doctors (one actually called the pharmacist in front of me to ask how long percocets stayed in your system – when I was under the impression when I researched and found only 21 doctors in the state of MD that were able to prescribe suboxone that there must have been some sort of training for that certification) was unbelievably discouraging. I know I am a persistent and resourceful person and if I couldn't find the help I needed I could only imagine what impression that someone less so would have. Being told there is a waiting list to get help and not providing an alternative in the interim is basically like saying keep doing what you're doing and try not to die until I see fit to squeeze you in. Seeking help from a doctor who will decide whether or not he likes you, and then tells you even though you're asking for help, found a sitter and drove over an hour away at the crack of dawn, that you aren't serious enough and need jail or Witsitt (neither being a viable option) is beyond frustrating. Telling friends or family or asking your family doctor introduces the stigma and shame. Our community conjures up the image of 'junkie' and, again, I don't fault them...people are generally scared of what they don't understand. However, that leaves addicts only source of help and recovery information other addicts. But worse than all these things, in my opinion, is that the medications most popularly offered to "help", methodone and suboxone are just as bad, if not worse in terms of habit forming and withdrawal, than the original affliction. Not only that, but the more popular, suboxone, can throw an opiate user into intense hyper-withdrawal by 'pushing out' any opiates in their system, if they don't wait until they are 'sick' enough. I may have mentioned that is generally what the addicts are AVOIDING. It's certainly not for lack of want that is keeping people from getting sober...I have never met an opiate addict who told me how much fun they were having or how much they enjoyed it...but plenty who were extremely tired of what they were doing and didn't know how to stop. IMHO, it would make a lot more sense to give an addict Subutex (buprenorphine without the opiate blocking naloxone and which you can take immediately) for at least a 96 hour period...then it could be following by the Suboxone in immediate, but slowly, gradually reducing doses followed by a week or two treatment of some sort of stimulant/B12. That would eliminate the fear of the painful withdrawal, work towards immediately weaning the addict from opioids, and provide the extra boost of energy that they are missing at low dose for a short period (to avoid any potential secondary or replacement addiction). I also feel it is asinine to boot anyone seeking treatment out of any treatment program. As long as the prescribed medication can be found in their system it shouldn't matter if anything else is in there. They didn't become drug addicts overnight so should not be expected to recover overnight and them being there and trying is far better than the alternative. Nor is jail an effective tool for all addicts – and with the epidemic spreading to different demographics I imagine it will be less and less so. I've never been in trouble in my life until now. Going to jail (an error of the probation office and a lie from another drug addict, so for no real reason at all – but I introduced the court and those people into my life, so no ones fault but my own) cost me my business, my home, almost everything I owned and separated me from my children who hadn't been out of my sight longer than a weekend in their lives (13 years for my oldest). Facing this type of adversity, especially after being pain free (including emotionally) for several years is not very conducive to encouraging sobriety. There has to be some less disruptive, more supportive options. Drug court, intensive outpatient treatment, therapy, support groups, resources for regrouping and rebuilding lives – none of which are found in jail. I don't know what limitations your Task Force is facing, but felt I could offer a 'real-life' perspective in terms of what could have helped me and to offer my help or insight in any way that would benefit you to curb the spread of this disease.

Very kind regards,

Dena Anthony

Notes for Heroin Task Force: June 10, 2015:

Dear Lt. Governor Rutherford:

Thank you so much for coming to Wicomico County and to hear the needs of the Lower Shore!

Having been on site as Re-entry Coordinator for just over a year and have identified many needs this county has especially in regards to the reintegration of inmates back into the community. I have a fairly extensive and eclectic background in the criminal justice field and with addicts particularly. Although heroin may appear to be epidemic, many individuals are still using cocaine and THC.

Substance abuse does not start out as a disease but it certainly can lead to disease due to physiological changes in the brain and body. Globally, some studies, however, have shown that many addicts choose rewards over drugs instead which indicates that there is a choice component and therefore not all are so addicted that they cannot give it up. Many more need extensive treatment and education. For some young folks, low self-esteem, peer pressure and the unfortunate desire to fit in no matter what can also lend a hand down the path to addiction. According to National Institute on Drug Abuse (NIDA) the 5 greatest contributing factors to addiction are: 1. Stress 2. Early physical or sexual abuse. 3. Witnessing violence (most of our youth are exposed to this frequently) 4. Peers who use drugs. 5. Drug availability. The larger, underlying question is not just how do we reduce the drug problem, but also why are so many citizens wanting to escape into substance abuse?

After having participated in Time 1 &2 NIDA/UMBC Drug study of women IV drug users, the majority were heroin users (although not always exclusively) and I was appalled at their horrific stories: 80% had survived many kinds of abuse, parental and peer drug use, and poor childhoods as well as rape and domestic violence. We had 4 researchers each of whom interviewed @150 women. The instrument (survey) took between 2 and 4 hours per woman with the length being based on the length of their history. Many were so dope sick they could not complete the

survey. @20% had been on Methadone for up to 20 years just so that they were able to go to work.

Much later I worked with 50 (that is 1 unit in 1 prison in the U.S.) DIAGNOSED mentally ill and personality disordered inmates on a maximum security unit in Massachusetts. My role was to run classes aimed at enhancing their knowledge base, coping skills or re-entry preparation. These were men aged 23 to 70. Of the drug users, it is impossible for me to imagine what their "childhoods" must have been like. Children who were kicked, locked up, starved and abused psychologically and physically. One 52 year old man had been raped repeatedly by priests and had never been able to fully function even though he was highly intelligent. Many had survived multiple foster homes. One fellow @ 38 years old had lived most of his childhood with 7 other foster children plus several of the parent's biological children, all of whom were all told to leave the home early in the morning and not return until dinner time. The foster parents were paid to care for them but provided no food or care during the day. No one cared if he went to school or what he did during the day and so he learned to smoke, use drugs and commit petty theft, sometimes just to eat, that ultimately lead to more severe crimes. He barely made it through 7th grade. The only positive memory he recalled of his foster parents was watching TV while the foster father smoked pot and drank and once when he was taken fishing.

We had a one eyed, 58 year old, Cuban man who had been thrown out of Cuba when he was 9 and put on a boat with other prisoners bound for Florida. His crime was that he had been charged with stealing food. He was illiterate, developmentally disabled and unable to learn to read. He developed SMI, committed many minor crimes while growing up in Florida, and finally had murdered someone who had tried to take his meager belongings while he had been homeless. The Mental Health Management I worked for bought him a glass eye, but one day he became extremely agitated and ate it.

Since our office was on the prison unit, we became the family the inmates never had. Between the highly qualified mental health clinicians and myself running classes, the prison was able to downgrade 75% of these maximum security inmates to medium security. Most of these inmates were headed for release.

Many of these inmates were self-mutilators and had the myriad scars to prove it. Some would become anxious about one thing or another and write their objections in blood on the walls of their cells.

Not all future drug users come from uncaring or inattentive homes. I worked for an investigator in Massachusetts for 6 years who lived an upper middle class life. He and his wife had raised two children. The son graduated college and started his own business and the daughter whom the family had attempted, unsuccessfully, to refer to a psychiatrist, moved to Florida to take up drugs and biker gangs. She then began to have children. She has had 5 to date. She is now in her 40s. She had no interest in the children per se, but cashed the monthly check for their maintenance. Finally, Child Protective Services took one child and my boss adopted a girl. The woman's aunt adopted another child and that left two. After two years of my boss calling Social Service, they finally came and took the girl which left her 11 year old son. Last week I received a call from him saying that the police in Florida stopped an 11 year old driving his mother's stolen car all over the road. When the police asked him what he was doing he said, "I am trying to kill myself." What chance do her children have of avoiding drug use to cope with their psychic pain? After all, most people take substances that affect their brain function to CHANGE THEIR STATE OF MIND. They do not want to be the person, or in the state of being, that they are. Think about why you might have a beer or a glass of wine. How easy would it be for you to never have one again? I asked a co-worker the other day if she would consider stopping smoking (I could hear the raspy congestion her poor lungs were trying to expel) and she said," I can't think of a reason to stop."

I am not going to address the necessities of substance abuse treatment, law enforcement, reducing distribution, getting dealers off the streets because everyone knows that those are important components to the "war on drugs." My focus is to talk about what I feel the Country, as a whole, and Maryland in specific, needs to address and that is PREVENTION which is by far the greater cure.

Here are the suggestions that I would like to see Maryland take into consideration in regards to substance abuse:

1. Stop glamorizing crimes and drugs. No shows that depict handsome, successful drug dealers, no ads for e cigarettes or alcohol. Stop Television from focusing on the marvelous revenues on THC and Pot production start focusing on EDUCATION! Start early as in 7th grade in school. Talk about exactly what happens to your body and your brain on drugs. Talk about how agitated you can become on Marijuana and that nowadays it is even in cookie and candy and can be a gateway drug. When people say, "Oh I had a 90 year old grandma that smoked/did drugs" Talk about the quality of her life and what really happened to her body even though she was "Alive". In the 50s, tobacco companies used to target poor neighborhoods to give away cigarettes to young children and their parents in an effort to hook them and told them that "Menthol is actually soothing to your throat." Drug and alcohol use is a huge industry and very profitable.

2. Mandatory parenting classes especially for teens and those on Medical assistance: Doctors, DSS should insist on these classes and have parents demonstrate their ability to care for and raise a child. Get Fathers involved through paternity leave to enable them to bod with their child but even though you can do everything right as a parent, some children have undiagnosed mental illness. Some children are driven to suicide due to bullying. Why do we have

Bullying? How are kids learning to be bullies? What are their parents telling them? My friend Karen adopted 2 kids from Guatemala and it was a requirement for her and her husband to take parenting classes and the adoption agency scrutinized the home to which the children were going. We have parents in this country who are literally killing their children or at the very least, completely neglecting them. I met one the other day in my office.

3. During the Reagan administration, many mental hospitals were closed down. We need more treatment for the mentally ill and it is time people were actually diagnosed and had a place to go for care for long term care.

4. We have trained teachers already in the schools. We need repetitive, good quality, engaging education in conjunction with treatment, stiff penalties for distribution and within a few years, we will start to see a real decline in all drug use including heroin. One of the classes I taught at the prison in Massachusetts was called Character Counts which is a national school age program designed by the Josephson Institute Center for Youth Ethics. The premise of this program teaches the 6 pillars of character none of which had been covered in any school those inmates had attended.

5. Re-entry Preparation: Most inmates returning to their communities, are only focused on the day of release. They need to be prepared for success and connected to the agencies and services they need so that they can avoid drug use, violations of probation, returning to incarceration and ultimate failure. Many of the individuals with whom I have worked at intelligent and motivated to lead productive lives, but they often have no idea how to start in the right direction. Although Wicomico County has been the "pilot" Re-entry program

for the Eastern Shore, I am eager to get some programming started in other counties and jails. Knowledge is power.

Thank you so much for your time. I hope I have not taken too much of it.

Janet K. Lane, Wicomico County Re-entry Coordinator

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Salisbury, MD 21801
410-713-3737

wt 205 of O'Malley
w/ Call Penelope
for update

MARYLAND CENTER FOR SCHOOL SAFETY

PREPARE. PREVENT. ACHIEVE.

The Maryland Center for School Safety was created by the General Assembly in 2013 to work with public school and law enforcement stakeholders to ensure a comprehensive and coordinated approach to school safety, including disseminating information on best practices, providing training and technical assistance, and gathering meaningful data on school safety issues to ensure our schools are a safe and supportive environment. Additionally, a Center Governing Board was established to develop an implementation plan to phase in establishment and operation of the Center; provide general oversight and direction to the Center; and approve the annual budget for the Center. The Governor appointed State Superintendent of Schools, Dr. Lillian M. Lowery, as chair. A representative of the local Superintendents of Schools and Maryland Association of Boards of Education are members of the Governing Board.

Mr. Edward A. Clarke was hired as the Executive Director of the Maryland Center for School Safety. He brings thirty-seven years of combined law enforcement and school safety experience to the position.

Outlined below is a summary of the Maryland Center for School Safety core functions:

- Serve as a safe school information and best practices clearinghouse for stakeholders of up-to-date, research-based, and data-driven information on effective strategies for creating and maintaining safe schools as well as violence prevention.
- Develop a website containing a searchable database of definitive research, books, videos, white papers, speakers, websites, and other school safety resources.
- Initiate collaborative partnerships and facilitate coordination among local school systems, law enforcement agencies, state and local government, and community organizations to leverage existing resources to deliver school safety services uniformly to local school systems.
- Consolidate resources among stakeholders to maximize support and secure necessary skills to ensure emergency plan implementation and non-duplication of effort in emergency response procedures.
- Assist in the development of safety and security criteria for the design and operation of school facilities.
- Assist local school systems to monitor local school systems and individual school behavior data to ensure fairness in the application of consequences for student misbehavior.
- Work with the Maryland State Department of Education to establish a comprehensive, uniform, consistent process for collecting, evaluating and communicating school safety data as well as producing an annual report for policymakers and the public.
- Foster coordination and collaboration among all entities responsible for ensuring the safety and security of school facilities in the State and assist local school systems in reducing the potential for pedestrian and vehicle accidents in the immediate vicinity of schools.

The Center for School Safety is housed at the Maryland Coordination and Analysis Center (MCAC), the State's Fusion Center. Questions or comments as to the Center's Mission can be addressed to Mr. Clarke at Edward.Clarke@mcac.maryland.gov or 301-370-3497.